Sch 6/985/86

PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

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STUDENT HANDBOOK

ACADEMIC YEAR 1985 - 1986

Indian Health Services
Health Resources and Services Administration
Public Health Service
Department of Health and Human Services

HE20.9408:

INTRODUCTION

Congratulations! In the Indian Health Care Improvement Act, Public Law 94-437, the Congress and the President of the United States established a national goal: "to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level." To accomplish this goal, the Act, and subsequent amendments of 1980, authorize the Indian Health Service to conduct three interrelated scholarship programs to train the health professional personnel necessary to staff IHS health programs and other health programs serving the Indian people. You are the recipient of one of the following scholarship programs:

Health Professions Preparatory Scholarship Program - Section 103

Health Professions Pregraduate Scholarship Program - Section 103P, or

Health Professions Scholarship Program - Section 104.

The administration of this program is a complex job and involves an array of requirements for which YOU ARE DIRECTLY RESPONSIBLE. These requirements cover the gamut from financial benefits, such as payment for books and travel, to report matters, such as course load and academic standing to maintain scholarship support, and application for placement to satisfy your payback obligation.

The Handbook is intended for use by all IHS scholarship recipients. It is designed to enhance your knowledge and understanding of the reporting requirements you must fulfill to receive scholarship support. Used properly, this Handbook curtails time-consuming correspondence or costly telephone calls. It gives you immediate access to guidance for situations not previously encountered. It also contains a sufficient supply of all the forms you may need and contains the names and addresses of IHS personnel you may need to contact.

Questions or matters requiring clarification should be directed to your IHS Area/Program Office Scholarship Coordinator.

M. Kay Carpentier
M. Kay Carpentier
Grants Management Officer
Grants and Contracts Management Branch
Indian Health Service

Pierre Colombel
Pierre Colombel
Chief, Human Resources Management Branch
Indian Health Service

PUBLIC LAW 94-437 STUDENT HANDBOOK

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NOTICE OF GRANT AWARD

SECTION A

NOTICE OF GRANT AWARD

Enclosed with your notification of scholarship award is the Notice of Grant Award (NOGA) and the grant award conditions which you must fulfill in order to receive funding under the scholarship. The NOGA is the official legal document between the Indian Health Service (IHS) and you awarding the scholarship and obligating the IHS to pay the costs of the scholarship. You should retain the NOGA and all future award documents for your records.

You should familiarize yourself with the NOGA and understand what the information on it means. Refer to page A-03 for a sample of the NOGA and a description of what each line means.

TYPES OF GRANT ACTION

There are five types of award and modification actions for which the standard NOGA form is used and which will probably, at some point during your scholarship, affect you. These actions are:

(1) Initial Award - This action funds the first "budget period" of the scholarship. The budget period (item 7 on the NOGA) is usually 12 months for Section 104 students and 10 months for students under Sections 103 and 103P. The budget period represents the period of time during which you will be paid stipend and during which the IHS will pay the costs of your tuition. If you incur costs before or after the dates of the budget period, you are not covered by the scholarship and these costs will not be paid by the IHS. (See page A-04 for sample initial award.)

(2) Continuation Award - This action funds renewals of your scholarship for each budget period beyond the initial one. (See page A-05.)

(3) Supplemental - This action is used to add monies during a budget period for increases in such items as tuition (based on actual billing by the school), special equipment, tutorial services, etc. Check the "Remarks" section of the NOGA for explanation of why the additional funds were awarded. There are also negative supplemental actions used to decrease funds from a scholarship that has been terminated. (See page A-06.)

(4) Change - Administrative - This action is merely a "housekeeping" document officially changing name, address, school, etc. It does not change the amount of money in the budget period. Check the "Remarks" section of the NOGA for explanation of the reason for the change. (See page A-07 for a sample change document.)

(5) Extension - This action extends the "budget period" to allow a Section 103 or 103P student to attend summer school or to allow a Section 104 student to complete an additional short period of time necessitated by a change in graduation date. Extensions usually involve the addition of funds to cover costs such as stipend and tuition for the period of extension. (See page A-08 for a sample.)

NOTICE OF GRANT AWARD

It is your responsibility to check all NOGAs which you receive and to alert your Area/Program Scholarship Coordinator if any information appears incorrect. For example, if your budget period ends in December and you do not plan to graduate until June, it is your responsibility to contact your Area/Program Scholarship Coordinator and request an extension of your scholarship.

READEX FICHE

best copy available

EXPLANATION OF FORM FOR NOGA

A-03

1. DATE ISSUED *Mo./Day/Yr.* — Date Signed

2. FEDERAL CATALOG NO. — Program #

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

3. SUPERSEDES AWARD NOTICE dated Date of Previous NOGA except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.

NOTICE OF GRANT AWARD

Type of Grant Action

4. GRANT NO. Number assigned to your award and the Formerly: budget period

5. ADMINISTRATIVE CODES — Internal program #

6. PROJECT PERIOD *Mo./Day/Yr.* — From Total time scholarship has been funded Through *Mo./Day/Yr.*

7. BUDGET PERIOD *Mo./Day/Yr.* — From Period of time covered by the current award Through *Mo./Day/Yr.*

AUTHORIZATION (Legislation/Regulation)
Specifies the section of the law under which you are funded this budget period (103, 103P, 104)

8. TITLE OF PROJECT (OR PROGRAM) *(Limit to 53 spaces)*
Type of scholarship awarded this budget period and major for which you are approved

9. GRANTEE
a. Name: Your name
b. Organization Unit:
c. Street: Stipend mailing address. If you have direct deposit, your permanent mailing address will be used.
d. City — e. State — f. Zip Code

10. DIRECTOR OF PROJECT (PROGRAM OR CENTER DIRECTOR, COORDINATOR OR PRINCIPAL INVESTIGATOR)
NAME: Name of assigned Scholarship Coordinator (*Last — First — Initial*)
ADDRESS: Information on your Scholarship Coordinator

11. APPROVED BUDGET *(Excludes PHS Direct Assistance)*
I ☐ Grand Funds Only
II ☐ Total project costs including grant funds and all other financial participation

a. Personal Service ..... Stipend	$ Amount for this budget period
b. Fringe Benefits	
c. Consultants	
d. Travel ..... ***	*** Amount for this expense (LUMP SUM)
e. Equipment ..... Miscellaneous***	
f. Supplies ..... Books***	
g. Contractual	
h. Patient Care	
i. Construction (A&R)	
j. Trainee Costs ..... Tuition	Estimated cost
k. Other	
l. TOTAL DIRECT COSTS	$ Total this budget
m. Indirect Costs ..... (Rate % of S&W/TADC)	$ period
n. TOTAL APPROVED BUDGET	$ Total Award this Budget Period
o. Federal Share	$ Total Amount Awarded
p. Non-Federal Share*	$ 0

*Must meet all matching or cost participation requirements. Subject to adjustment in accordance with PHS policy.

12. AWARD COMPUTATION FOR GRANT

a. Amount of PHS Financial Assistance (from 11.o)	$ Total funds this budget period
b. Less Unobligated Balance From Prior Budget Periods	$ N/A
c. Less Cumulative Prior Award(s) This Budget Period	Funds awarded to $ date
d. AMOUNT OF THIS ACTION	$ Amount of funds that are added/deducted by this NOGA

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT).

BUDGET YEAR	TOTAL DIRECT COSTS	BUDGET YEAR	TOTAL DIRECT COSTS
a.		e.	
b.		f.	
c.		g.	
d.			

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)

a. Personal Services	$
b. Travel	
c. Vaccine	
d. Other	
e. TOTAL DIRECT ASSISTANCE	$

15. PROGRAM INCOME SUBJECT TO 45 CFR 74.45 SHALL BE:
a. ☐ Used to further the objectives of the legislation under which the grant was made. b. ☐ Deducted from total project costs for the purpose of determining the net costs on which the Federal share of costs shall be based. c. ☐ Other - See Special Conditions d. ☐ NA

16. THIS GRANT IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under Remarks.
d. PHS Grants Administration Manual Chapters in effect as of the beginning date of the budget period.
e. PHS Grants Policy Statement in effect as of the beginning date of the budget period.
f. 45 CFR Part 74.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS *(Other Terms & Conditions Attached - Yes No)*
School for which you are approved this budget period

Information and explanation about this NOGA

AGENCY OFFICIAL *(Signature, Name and Title)*

17. PHS LIST NO. / OBJ. CLASS.		18. CRS - EIN Your Social Security	19. ORGANIZATION DESCRIPTORS:	
FY-CAN	DOCUMENT NO.	SECONDARY ADM. CODE	AMT. ACTION FIN. ASST.	AMT. ACTION DIR. ASST.
20. a. Internal funding information	b.	c.	d.	e.
21. a.	b.	c.	d.	e.
22. a.	b.	c.	d.	e.

PHS-5152-1 (REV. 12-76) (NOTE: See reverse for payment information)

A-04

1. DATE ISSUED Mo./Day/Yr. 07/02/84

2 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

NOTICE OF GRANT AWARD

INITIAL AWARD
NV AREA OFFICE/IHS

2 FEDERAL CATALOG NO. 13.971

3. SUPERSEDES AWARD NOTICE dated _____ except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.

4. GRANT NO. ISF00 0020-01
Formerly:

5. ADMINISTRATIVE CODES ISF18

6. PROJECT PERIOD Mo./Day/Yr. From 08/01/84 Through 05/31/85

7. BUDGET PERIOD Mo./Day/Yr. From 08/01/84 Through 05/31/85

AUTHORIZATION (Legislation/Regulation)
P.L. 94-437 SECTION 103
CFR 42 PART 36 SUBPART J

8. TITLE OF PROJECT (OR PROGRAM) (Limit to 33 spaces)
HLTH PREP SCHOL - NURSING

9. GRANTEE
a. Name SMITH, ALICE
b. Organization Unit:
c. Street PO BOX 111
d. City GALLUP e. State NM f. Zip Code 87301

10. DIRECTOR OF PROJECT (PROGRAM OR CENTER DIRECTOR, COORDINATOR OR PRINCIPAL INVESTIGATOR)
NAME Last SCHOLARSHIP First COORDINATOR Initial (NV AREA
TELEPHONE: (602)-871-5831
ADDRESS: PO BOX G
WINDOW ROCK, AZ 86515

11. APPROVED BUDGET (Excludes PHS Direct Assistance)
I ☐ Grand Funds Only
II ☐ Total project costs including grant funds and all other financial participation

a. Personal Ser (STIPEND)	$	5770
b. Fringe Benefits		0
c. Consultants		0
d. Travel		200 ***
e. Equipment (MISCELLANEOUS)		50 ***
f. Supplies (BOOKS)		300 ***
g. Contractual		0
h. Patient Care		0
i. Construction (A & R)		0
j. Trainee Costs (TUITION)		1750
k. Other		0
l. TOTAL DIRECT COSTS	$	8070
m. Indirect Costs (Rate % of S&W/TADC)	$	0
n. TOTAL APPROVED BUDGET	$	8070
o. Federal Share	$	8070
p. Non-Federal Share*	$	0

*Must meet all matching or cost participation requirements. Subject to adjustment in accordance with PHS policy.

12. AWARD COMPUTATION FOR GRANT

a. Amount of PHS Financial Assistance (from 11.a)	$ 8070
b. Less Unobligated Balance From Prior Budget Periods	$ 0
c. Less Cumulative Prior Award(s) This Budget Period	$ 0
d. AMOUNT OF THIS ACTION	$ 8070

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT).

BUDGET YEAR	TOTAL DIRECT COSTS	BUDGET YEAR	TOTAL DIRECT COSTS
a.		e.	
b.		f.	
c.		g.	
d.			

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)
a. Personal Services $
b. Travel
c. Vaccine
d. Other
e. TOTAL DIRECT ASSISTANCE $

15. PROGRAM INCOME SUBJECT TO 45 CFR 74.45 SHALL BE:
a. ☐ Used to further the objectives of the legislation under which the grant was made. b. ☐ Deducted from total project costs for the purpose of determining the net costs on which the Federal share of costs shall be based. c. ☐ Other - See Special Conditions d. ☒ NA

16. THIS GRANT IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under Remarks.
d. PHS Grants Administration Manual Chapters in effect as of the beginning date of the budget period.
e. PHS Grants Policy Statement in effect as of the beginning date of the budget period.
f. 45 CFR Part 74.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms & Conditions Attached - ☐ Yes ☒ No)
UNIV OF NEW MEXICO
NURSING DEPT.
GALLUP, NM 87301

*** $550 LUMP SUM TO STUDENT

AGENCY OFFICIAL (Signature, Name and Title)
GRANTS MANAGEMENT OFFICER: M. Kay Carpenter 07/02/84

17. PHS LIST NO. OBJ. CLASS. 41.21 18. CRS - EIN 000-00-0000 19. ORGANIZATION DESCRIPTORS:

	FY-CAN	DOCUMENT NO.	SECONDARY ACM. CODE	AMT. ACTION FIN. ASST.	AMT. ACTION DIR. ASST.
20.	a. 4-940445	b. ISF001837A	c.	d.	e.
21.	a.	b.	c.	d.	e.
22.	a.	b.	c.	d.	e.

PHS-5152-1 (REV. 12-76) (NOTE: See reverse for payment information)

A-05

1. DATE ISSUED Mo./Day/Yr. 06/01/84

2. FEDERAL CATALOG NO. 13.972

3. SUPERSEDES AWARD NOTICE dated 06/01/83 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.

4. GRANT NO. ISF00 0001-04
Formerly:

5. ADMINISTRATIVE CODES ISF19

6. PROJECT PERIOD Mo./Day/Yr. From 08/01/81 Through 07/31/85

7. BUDGET PERIOD Mo./Day/Yr. From 08/01/84 Through 07/31/85

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

NOTICE OF GRANT AWARD
NONCOMPETING CONTINUATION
TU AREA OFFICE/IHS

AUTHORIZATION (Legislation/Regulation)
P.L. 94-437 SECTION 104
CFR 42 PART 36 SUBPART J

8. TITLE OF PROJECT (OR PROGRAM) (Limit to 33 spaces)
HLTH PROF SCHOL - LAB TECH

9. GRANTEE
a. Name: DOE, JAMES
b. Organization Unit:
c. Street: RT 2 BOX 88
d. City: TUCSON e. State: AZ f. Zip Code: 85746

10. DIRECTOR OF PROJECT (PROGRAM OR CENTER DIRECTOR, COORDINATOR OR PRINCIPAL INVESTIGATOR)
NAME: TELEPHONE: 602-629-6751
Last: SCHOLARSHIP COORDINATOR (TU AREA)
ADDRESS: PO BOX 11340
TUCSON, AZ 85734

11. APPROVED BUDGET (Excludes PHS Direct Assistance)
I ☐ Grant Funds Only
II ☐ Total project costs including grant funds and all other financial participation

a. Personal Services (STIPEND)	$	6924
b. Fringe Benefits		0
c. Consultants		0
d. Travel		200 ***
e. Equipment (MISCELLANEOUS)		50 ***
f. Supplies (BOOKS)		300 ***
g. Contractual		0
h. Patient Care		0
i. Construction (A & R)		0
j. Trainee Costs (TUITION)		675
k. Other		0
l. TOTAL DIRECT COSTS	$	8149
m. Indirect Costs (Rate % of S&W/TADC)	$	0
n. TOTAL APPROVED BUDGET	$	8149
o. Federal Share	$	8149
p. Non-Federal Share*	$	0

*Must meet all matching or cost participation requirements. Subject to adjustment in accordance with PHS policy.

12. AWARD COMPUTATION FOR GRANT

a. Amount of PHS Financial Assistance (from 11.o)	$	8149
b. Less Unobligated Balance From Prior Budget Periods	$	0
c. Less Cumulative Prior Award(s) This Budget Period	$	0
d. AMOUNT OF THIS ACTION	$	8149

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT).

BUDGET YEAR	TOTAL DIRECT COSTS	BUDGET YEAR	TOTAL DIRECT COSTS
a.		e.	
b.		f.	
c.		g.	
d.			

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)

a. Personal Services	$
b. Travel	
c. Vaccine	
d. Other	
e. TOTAL DIRECT ASSISTANCE	$

15. PROGRAM INCOME SUBJECT TO 45 CFR 74.45 SHALL BE:
a. ☐ Used to further the objectives of the legislation under which the grant was made. b. ☐ Deducted from total project costs for the purpose of determining the net costs on which the Federal share of costs shall be based. c. ☐ Other - See Special Conditions d. ☒ NA

16. THIS GRANT IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under Remarks.
d. PHS Grants Administration Manual Chapters in effect as of the beginning date of the budget period.
e. PHS Grants Policy Statement in effect as of the beginning date of the budget period.
f. 45 CFR Part 74.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms & Conditions Attached - ☐ Yes ☒ No)
PIMA COM COLLEGE
2202 W ANKLAM RD
TUCSON, AZ 85709

***LUMP SUM $550 AWARDED TO STUDENT TO COVER THESE EXPENSES

AGENCY OFFICIAL (Signature, Name and Title)
GRANTS MANAGEMENT OFFICER: M. Kay Carpenter 06/01/84

17. PHS LIST NO. OBJ. CLASS. 41.21 18. CRED. EIN 000-00-0000 19. ORGANIZATION DESCRIPTORS:

	FY-CAN	DOCUMENT NO.	SECONDARY ADM. CODE	AMT. ACTION FIN. ASST.	AMT. ACTION DIR. ASST.
20. a.	4-3940450	b. ISF001271A	c.	d.	e.
21. a.		b.	c.	d.	e.
22. a.		b.	c.	d.	e.

PHS-5152-1 (REV. 12-76) (NOTE: See reverse for payment information)

A-06

1. DATE ISSUED Mo./Day/Yr. 03/06/85

2. FEDERAL CATALOG NO. 13.972

3. SUPERSEDES AWARD NOTICE dated 06/01/84 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.

4. GRANT NO. ISF00 0025-03-1
Formerly:

5. ADMINISTRATIVE CODES ISF19

6. PROJECT PERIOD Mo./Day/Yr. From 08/01/83 Through 07/31/85

7. BUDGET PERIOD Mo./Day/Yr. From 08/01/84 Through 07/31/85

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

NOTICE OF GRANT AWARD
SUPPLEMENTAL
US AREA OFFICE/IHS

AUTHORIZATION (Legislation/Regulation)
P.L. 94-437 SECTION 104
CFR 42 PART 36 SUBPART J

8. TITLE OF PROJECT (OR PROGRAM) (Limit to 55 spaces)
HLTH PROF SCHOL-NURSING

9. GRANTEE
a. Name JONES, DAVID
b. Organization Unit:
c. Street P.O. BOX 141
d. City PERRY e. State ME f. Zip Code 04667

10. DIRECTOR OF PROJECT (PROGRAM OR CENTER DIRECTOR, COORDINATOR OR PRINCIPAL INVESTIGATOR)
NAME Last TELEPHONE: 615-251-5104
First SCHOLARSHIP COORDINATOR (US AREA) Initial
ADDRESS: 1101 KERMIT DR SUITE 810
NASHVILLE, TN 37217

11. APPROVED BUDGET (Excludes PHS Direct Assistance)
I [ ] Grand Funds Only
II [X] Total project costs including grant funds and all other financial participation

a. Personal Services (STIPEND)	$ 6924
b. Fringe Benefits	0
c. Consultants	0
d. Travel	200
e. Equipment (MISCELLANEOUS)	50
f. Supplies (BOOKS)	300
g. Contractual	0
h. Patient Care	0
i. Construction (A & R)	0
j. Trainee Costs (TUITION)	6650
k. Other	0
l. TOTAL DIRECT COSTS	$ 14124
m. Indirect Costs (Rate % of S&W/TADC)	$ 0
n. TOTAL APPROVED BUDGET	$ 14124
o. Federal Share	$ 14124
p. Non-Federal Share*	$ 0

*Must meet all matching or cost participation requirements. Subject to adjustment in accordance with PHS policy.

12. AWARD COMPUTATION FOR GRANT

a. Amount of PHS Financial Assistance (from 11.o)	$ 14124
b. Less Unobligated Balance From Prior Budget Periods	$ 0
c. Less Cumulative Prior Award(s) This Budget Period	$ 13584
d. AMOUNT OF THIS ACTION	$ 540

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT).

BUDGET YEAR	TOTAL DIRECT COSTS	BUDGET YEAR	TOTAL DIRECT COSTS
a.		e.	
b.		f.	
c.		g.	
d.			

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)

a. Personal Services	$
b. Travel	
c. Vaccine	
d. Other	
e. TOTAL DIRECT ASSISTANCE	$

15. PROGRAM INCOME SUBJECT TO 45 CFR 74.45 SHALL BE:
a. [ ] Used to further the objectives of the legislation under which the grant was made.
b. [ ] Deducted from total project costs for the purpose of determining the net costs on which the Federal share of costs shall be based.
c. [ ] Other - See Special Conditions
d. [X] NA

16. THIS GRANT IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under Remarks.
d. PHS Grants Administration Manual Chapters in effect as of the beginning date of the budget period.
e. PHS Grants Policy Statement in effect as of the beginning date of the budget period.
f. 45 CFR Part 74.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms & Conditions Attached - [ ] Yes [ ] No) X
WESTBROOK COLL
STEVENS AVE
PORTLAND, ME 04103

SUPPLEMENTS TUITION BY $540
TO ALLOW FULL PAYMENT TO SCHOOL

AGENCY OFFICIAL (Signature, Name and Title)
GRANTS MANAGEMENT OFFICER: M. Kay Carpenter 03/06/85

17. PHS LIST NO. | OBJ. CLASS. 41.21 | 18. CRS | EIN 000-00-0000 | 19. ORGANIZATION DESCRIPTORS:

	FY-CAN	DOCUMENT NO.	SECONDARY ACM. CODE	AMT. ACTION FIN. ASST.	AMT. ACTION DIR. ASST.
20. a.	5-3940450	b. ISF001714A	c.	d.	e.
21. a.		b.	c.	d.	e.
22. a.		b.	c.	d.	e.

PHS-5152-1 (REV. 12-76) (NOTE: See reverse for payment information)

1. DATE ISSUED Mo./Day/Yr. 10/10/84

2. FEDERAL CATALOG NO. 13.972

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

A-07

HEALTH RESOURCES AND SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE
NOTICE OF GRANT AWARD
CHANGE-(ADMINISTRATIVE)
BL AREA OFFICE/IHS

3. SUPERSEDES AWARD NOTICE dated 09/17/84 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.

4. GRANT NO. Formerly: ISF00 0030-03-01

5. ADMINISTRATIVE CODES ISF19

6. PROJECT PERIOD From 08/01/82 Through 07/31/85

7. BUDGET PERIOD From 08/01/84 Through 07/31/85

AUTHORIZATION (Legislation/Regulation)
P.L. 94-437 SECTION 104
CFR 42 PART 36 SUBPART J

8. TITLE OF PROJECT (OR PROGRAM) (Limit to 55 spaces)
HLTH PREP SCHOL - NURSING

9. GRANTEE
a. Name THOMAS, JOHN
b. Organization Unit:
c. Street 2420 ROBIN LANE
d. City BROWNING e. State MT f. Zip Code 59417

10. DIRECTOR OF PROJECT (PROGRAM OR CENTER DIRECTOR, COORDINATOR OR PRINCIPAL INVESTIGATOR)
NAME Last SCHOLARSHIP First COORDINATOR Initial (BL AREA)
TELEPHONE: 406-657-6169
ADDRESS: 2727 CENTRAL AVE BOX 2143
BILLINGS, MT 59103

11. APPROVED BUDGET (Excludes PHS Direct Assistance)
I [ ] Grand Funds Only
II [X] Total project costs including grant funds and all other financial participation

a. Personal Services (STIPEND)	$ 6924
b. Fringe Benefits	0
c. Consultants	0
d. Travel	200
e. Equipment (MISCELLANEOUS)	50
f. Supplies (BOOKS)	300
g. Contractual	0
h. Patient Care	0
i. Construction (A&R)	0
j. Trainee Costs (TUITION)	900
k. Other	0
l. TOTAL DIRECT COSTS	$ 8374
m. Indirect Costs (Rate % of S&W/TADC)	$ 0
n. TOTAL APPROVED BUDGET	$ 8374
o. Federal Share	$ 8374
p. Non-Federal Share*	$ 0

*Must meet all matching or cost participation requirements. Subject to adjustment in accordance with PHS policy.

12. AWARD COMPUTATION FOR GRANT

a. Amount of PHS Financial Assistance (from 11.0)	$ 8374
b. Less Unobligated Balance From Prior Budget Periods	$ 0
c. Less Cumulative Prior Award(s) This Budget Period	$ 8374
d. AMOUNT OF THIS ACTION	$ 0

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT).

BUDGET YEAR	TOTAL DIRECT COSTS	BUDGET YEAR	TOTAL DIRECT COSTS
a.		e.	
b.		f.	
c.		g.	
d.			

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)

a. Personal Services	$
b. Travel	
c. Vaccine	
d. Other	
e. TOTAL DIRECT ASSISTANCE	$

15. PROGRAM INCOME SUBJECT TO 45 CFR 74.45 SHALL BE:
a. [ ] Used to further the objectives of the legislation under which the grant was made.
b. [ ] Deducted from total project costs for the purpose of determining the net costs on which the Federal share of costs shall be based.
c. [ ] Other - See Special Conditions
d. [X] NA

16. THIS GRANT IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under Remarks.
d. PHS Grants Administration Manual Chapters in effect as of the beginning date of the budget period.
e. PHS Grants Policy Statement in effect as of the beginning date of the budget period.
f. 45 CFR Part 74.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms & Conditions Attached - Yes No) X
CORRECTS STUDENT ADDRESS
MONTANA ST UNIVER
BUSINESS OFFICE
BOZEMAN, MT 59715

AGENCY OFFICIAL (Signature, Name and Title)
GRANTS MANAGEMENT OFFICER: M Kay Carpenter 10/10/84

17. PHS LIST NO. OBJ. CLASS. 41.21 18. CRS / EIN 000-00-0000 19. ORGANIZATION DESCRIPTORS:

	FY-CAN	DOCUMENT NO.	SECONDARY ACN. CODE	AMT. ACTION FIN. ASST.	AMT. ACTION DIR. ASST.
20. a.	9-3940042	b. ISF001325A	c.	d.	e.
21. a.		b.	c.	d.	e.
22. a.		b.	c.	d.	e.

PHS-5152-1 (REV. 12-76) (NOTE: See reverse for payment information)

A-08

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

HEALTH RESOURCES AND SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE
NOTICE OF GRANT AWARD

EXTENSION
AQ AREA OFFICE/IHS

1. DATE ISSUED (Mo./Day/Yr.): 10/05/84
2. FEDERAL CATALOG NO.: 13.972
3. SUPERSEDES AWARD NOTICE dated 05/04/84 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.
4. GRANT NO.: Formerly: ISF00 0010-01-2
5. ADMINISTRATIVE CODES: ISF19
6. PROJECT PERIOD (Mo./Day/Yr.): From 08/01/83 Through 08/31/84
7. BUDGET PERIOD (Mo./Day/Yr.): From 08/01/83 Through 08/31/84

AUTHORIZATION (Legislation/Regulation)
P.L. 94-437 SECTION 104
CFR 42 PART 36 SUBPART J

8. TITLE OF PROJECT (OR PROGRAM) (Limit to 55 spaces)
HLTH PROF SCHOL - RADIOLOGY

9. GRANTEE
a. Name: BEAR, SUE
b. Organization Unit:
c. Street: PO BOX 12
d. City: ZUNI e. State: NM f. Zip Code: 87327

10. DIRECTOR OF PROJECT (PROGRAM OR CENTER DIRECTOR, COORDINATOR OR PRINCIPAL INVESTIGATOR)
NAME: Last TELEPHONE: 505-766-2133 First SCHOLARSHIP COORDINATOR (AQ AREA) Initial
ADDRESS: 500 GOLD AVE., SW, RM 4005
ALBUQUERQUE, NM 87101

11. APPROVED BUDGET (Excludes PHS Direct Assistance)
I [ ] Grand Funds Only
II [X] Total project costs including grant funds and all other financial participation

a. Personal Services (STIPEND)	$ 7501
b. Fringe Benefits	0
c. Consultants	0
d. Travel	200
e. Equipment (MISCELLANEOUS)	125
f. Supplies (BOOKS)	250
g. Contractual	0
h. Patient Care	0
i. Construction (A & R)	0
j. Trainee Costs (TUITION)	3159
k. Other	0
l. TOTAL DIRECT COSTS	$ 11235
m. Indirect Costs (Rate % of S&W/TADC)	$ 0
n. TOTAL APPROVED BUDGET	$ 11235
o. Federal Share	$ 11235
p. Non-Federal Share*	$ 0

*Must meet all matching or cost participation requirements. Subject to adjustment in accordance with PHS policy.

12. AWARD COMPUTATION FOR GRANT

a. Amount of PHS Financial Assistance (from 11.o)	$ 11235
b. Less Unobligated Balance From Prior Budget Periods	$ 0
c. Less Cumulative Prior Award(s) This Budget Period	$ 10658
d. AMOUNT OF THIS ACTION	$ 577

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT).

BUDGET YEAR	TOTAL DIRECT COSTS	BUDGET YEAR	TOTAL DIRECT COSTS
a.		e.	
b.		f.	
c.		g.	
d.			

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)

a. Personal Services	$
b. Travel	
c. Vaccine	
d. Other	
e. TOTAL DIRECT ASSISTANCE	$

15. PROGRAM INCOME SUBJECT TO 45 CFR 74.45 SHALL BE:
a. [ ] Used to further the objectives of the legislation under which the grant was made.
b. [ ] Deducted from total project costs for the purpose of determining the net costs on which the Federal share of costs shall be based.
c. [ ] Other - See Special Conditions
d. [X] NA

16. THIS GRANT IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation cited above.
b. The grant program regulation cited above.
c. This award notice including terms and conditions, if any, noted below under Remarks.
d. PHS Grants Administration Manual Chapters in effect as of the beginning date of the budget period.
e. PHS Grants Policy Statement in effect as of the beginning date of the budget period.
f. 45 CFR Part 74.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms & Conditions Attached - [ ] Yes [X] No)
UNIV OF ALBUQUERQUE
FINANCIAL AID OFFICE
ALBUQUERQUE, NM 87140

EXTENDS AWARD THROUGH 08/31/84
- STUDENT GRADUATES 08/17/84

AGENCY OFFICIAL (Signature, Name and Title)
GRANTS MANAGEMENT OFFICER: Charlie L. Wade 10/05/84

17. PHS LIST NO. OBJ. CLASS. 41.21 18. CRS - EIN 000-00-0000 19. ORGANIZATION DESCRIPTORS:

	FY-CAN	DOCUMENT NO.	SECONDARY ACM. CODE	AMT. ACTION FIN. ASST.	AMT. ACTION DIR. ASST.
20. a.	4-1940450	b. ISF001622A	c.	d.	e.
21. a.		b.	c.	d.	e.
22. a.		b.	c.	d.	e.

PHS-5152-1 (REV. 12-76) (NOTE: See reverse for payment information)

NOTICE OF GRANT AWARD

Grant Award Conditions

A copy of the Notice of Grant Award Conditions applicable for the school year is attached to the initial or continuation Notice of Grant Award sent to you. These conditions are of two types, standard and special.

Standard conditions are general conditions applicable to all scholarship recipients. They include: academic and reporting requirements which you must fulfill in order to receive scholarship support; information on payments; and, for Section 104, penalties and service obligation requirements.

Special conditions are specific requirements placed on individual students, as needed. Special conditions must be fulfilled in order to continue receiving scholarship support during a budget period. These requirements usually have deadline dates that must be met. Examples of special conditions are: submission of a Section 104 contract; probationary period for raising GPA; and requirement that student change to an accredited program.

You are responsible for reading the Notice of Grant Award Conditions carefully and for meeting all requirements, including any special conditions placed on your award. Your failure to fulfill both the standard and the special conditions will put your scholarship in jeopardy of termination.

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM
CONDITIONS OF GRANT AWARD
1985-1986 SCHOOL YEAR

INTRODUCTORY INFORMATION

PLEASE READ THESE STANDARD AND SPECIAL CONDITIONS CAREFULLY. Your failure to comply with them is grounds for termination of your scholarship award. The Public Law 94-437 Title I Scholarship, Program Student Handbook, Academic Year 1985-1986, provides general program information and specific guidance to assist you in complying with the scholarship requirements. Grantees who comply with these requirements are eligible for continued scholarship support beyond the budget period listed in item 7 of the Notice of Grant Award (NOGA) and in accordance with the provisions of the Act.

STANDARD CONDITIONS

I. IHS PERSONNEL INVOLVED WITH YOUR SCHOLARSHIP AWARD

A. Scholarship Coordinator

The address and telephone number of your Indian Health Service (IHS) Area/Program Office scholarship coordinator is listed in item 10 of the Notice of Grant Award. The role of the scholarship coordinator is to serve as your primary contact within the IHS for technical and programmatic questions and problems, to monitor your academic performance, and to provide assistance with any problems related to the scholarship or your academic performance.

B. Grants Management Officer

The grants management officer, IHS, is M. Kay Carpentier, Parklawn Building, Room 6A-29, 5600 Fishers Lane, Rockville, Maryland 20857; telephone number (301) 443-5204. The role of the grants officer is to complement the programmatic knowledge of the scholarship coordinator with expertise in administrative and non-programmatic areas such as issuance of grant awards and coordination of payments for tuition, travel, and stipends.

C. Headquarters Branch Chief

The role of the headquarters branch chief of your particular health discipline is to monitor your academic performance to assure your success in your health education. The branch chief also assists Section 104 recipients with Extern Placement and with placement to begin and complete Service Obligation Payback. Please refer to the Student Handbook for a listing of the headquarters branch chiefs.

II. ACADEMIC REQUIREMENTS

It is the policy of the Indian Health Service (IHS) that a recipient of a scholarship awarded under Sections 103 or 104 of the Indian Health Care Improvement Act must maintain a 2.0 cumulative grade point average and must be a full-time student (minimum of 12 credit hours). A grantee receiving a scholarship under the Section 103 Pregraduate Scholarship authority must maintain a 2.5 cumulative grade point average and must be a full-time student to be eligible for continuation. In addition to the two other requirements stated above, a Section 104 grantee must also be enrolled in an approved/accredited school for a health profession.

III. REPORTING REQUIREMENTS

The following reports must be sent to the IHS Area/Program Office scholarship coordinator identified in item 10 of the Notice of Grant Award as required below. If you fail to submit these reports as required you will be ineligible for continuation of scholarship support and your award will be terminated.

A. Recipient's Enrollment and Initial Program Progress Report

Within 30 days from the beginning of each semester or quarter, you must submit a Recipient's Enrollment and Initial Progress Report (see Student Handbook for form), signed by your school advisor or the registrar's office, verifying that you are enrolled in a full-time course load for the semester/quarter. A full-time course load is a minimum of 12 credit hours or the number of credit hours considered by your school as full-time. You must also submit a course curriculum outline, approved by your advisor, for your chosen health program.

B. Transcripts

Within thirty days from the end of each academic period, i.e., semester, quarter, or summer session, submit an OFFICIAL transcript for the academic period completed.

C. Notification of Academic Problem/Change

If at any time during the semester/quarter you reduce the number of credit hours for which you are enrolled below the minimum of 12, or if you experience academic problems, you must submit this report (see Student Handbook for form). If you are enrolled in at least 12 credit hours and are doing satisfactorily in all classes (at least a "C" or better), DO NOT SUBMIT THIS REPORT unless you want to alert your scholarship coordinator of a special problem you are experiencing or to request assistance, e.g., tutorial service or approval to drop a course.

D. Change of Status

1. Change of Academic Status

You must immediately notify the scholarship coordinator if you are placed on academic probation, are dismissed from school, or voluntarily drop for any reason (personal or medical).

2. School Transfer Request

Refer to the Student Handbook for acceptable reasons for transfer. At least 30 days prior to the time of transfer from the school cited on the NOGA, you must request approval of the change. State clearly the reason for the transfer and submit an acceptance letter from the school to which you are requesting transfer and verification of the number of earned college credits that will be transferable. You will be notified of the approval/disapproval of such a request. If you change schools without IHS approval, you will be dropped from the scholarship program.

3. Change of Major

You may not change from the approved major listed in item 8 of the NOGA during the school year. If you make an unapproved change, you will be dropped from the scholarship program. (See the Student Handbook for instructions on how and when you may change majors.)

4. Change in Graduation Date

At any time that a change occurs in your expected graduation date, notify your Scholarship Coordinator.

5. Program Change

Provide supportive documentation when requesting change from Section 103 to 104 (letter of acceptance from your chosen health professional program) or from 104 to 103 (verification that you are enrolled in a preparatory courses).

IV. PAYMENTS

A. Tuititon

The IHS Office, Rockville, Maryland arranges payment of all tuition and other mandatory fees, such as laboratory fees, upon receipt of a bill from your educational institution. The tuition amount, 11j of the Notice of Grant Award, is only an estimate for fall, winter, and spring sessions; it will be revised to cover all tuition costs as billed by the college or university. Payment of tuition and fees is made directly to the educational institution.

Summer school tuition and costs must be requested and approved in advance by the IHS. See the Student Handbook for additional information and for the required form.

B. Stipend, Books, Miscellaneous Educational Expenses, and Travel

You will receive the first stipend check by August 15, and monthly stipend checks thereafter by the first of the month. (See the Student Handbook regarding lost checks.)

The first check contains money for books for the Fall, Winter and Spring terms; miscellaneous educational expenses including $25.00 for post office box rental; and travel.

V. SECTION 104 PENALTIES

It is your responsibility to read and understand the IHS contract. In brief, the contract provides three penalties to which the Section 104 scholarship recipient is subject:

1. $1,500 fine if the Section 104 recipient, after both parties (recipient and representative of the U.S. Government) have signed the Indian Health Scholarship Program Contract, fails to accept payment or instructs the health professions school not to accept scholarship award payments or otherwise declines to accept the scholarship award. See special Warning of Liability, page 13.

2. Repayment of ALL scholarship funds paid directly to the student and on his/her behalf to a health professions school if the Section 104 recipient fails to maintain the required level of academic standing in the scholarship-funded curriculum, is dismissed from the health professions school for disciplinary reasons, or voluntarily terminates the curriculum for which scholarship is awarded.

3. Repayment of an amount equal to THREE TIMES the scholarship funds paid directly to the Section 104 recipient and on his/her behalf to the educational institution, plus interest at the prevailing interest rate, if student fails to begin or complete the period of service obligation.

VI. EXTERNSHIPS FOR SECTION 104 RECIPIENTS

A. Individuals receiving Section 104 scholarships are entitled to employment by the IHS for up to 120 days per calendar year during any non-academic period in accordance with the provisions of Section 105 of the Act. Section 104 scholarship recipients who will be graduating this academic year are not eligible. Refer to the Student Handbook for specific academic requirements.

B. Application: Each student must submit a Personal Qualifications Statement (SF 171) and the Extern Assignment Preference Form to your Area/Program Office Extern Coordinator. Deadline date for receipt of forms is close of business on February 1 or postmarked by midnight on January 29. Refer to the Student Handbook for additional information on the Extern Program and for forms.

VII. SERVICE OBLIGATION

Subject to applicable regulations and to the Indian Health Scholarship Program Contract, there is a requirement that a Section 104 recipient serve one year for each year of scholarship support which he/she receives. Minimum period of service is two years. The IHS will review assignment opportunities with each graduating student in the final school year and will work with the student to confirm an assignment. However, the ultimate responsibility for seeking a position is the scholarship recipient's.

The Director, IHS, reserves the right to make final decisions regarding assignment of scholarship recipients to fulfill their service obligation. Priority for assignment of graduates is currently given to placement in IHS facilities with vacant positions. Therefore, although the IHS will attempt to place the graduate in the geographic location of his/her choice, this may not be possible and the graduate may be required to take a position in another area.

In your the last year of your health professions program prior to your graduation, you must submit the required forms to the IHS Service Obligation Coordinator making application for either the Civil Service or the Public Health Service Commission Corps. Refer to the Student Handbook for additional information, specific deadline dates, and required forms.

SPECIAL CONDITIONS

This is applicable only if a special requirement or restriction has been added below.

PERSONNEL INVOLVED WITH

THE SCHOLARSHIP

SECTION B

PERSONNEL INVOLVED WITH THE SCHOLARSHIP AWARD

SCHOLARSHIP COORDINATOR

A complete listing of the Indian Health Service Area/Program Office Scholarship Coordinators follows this page. Your Scholarship Coordinator is identified in item 10 of the Notice of Grant Award. The role of the Area/Program Scholarship Coordinator is to serve as your primary contact within the IHS for technical and programmatic questions and problems, to monitor your academic performance, and to provide assistance with any problems related to the scholarship or your academic performance.

INDIAN HEALTH SERVICE AREA/PROGRAM OFFICES AND SPECIAL SCHOLARSHIP OFFICES

IHS AREA/PROGRAM OFFICE AND STATES/LOCALITY SERVED	ADDRESS OF AREA/PROGRAM	SCHOLARSHIP COORDINATOR	COMMERCIAL AND FTS TELEPHONE
Aberdeen Area IHS Iowa Nebraska North Dakota South Dakota	Aberdeen Area IHS Federal Office Building 115 4th Avenue Aberdeen, South Dakota 57401	Ms. Adeline Horst	Comm: 605-225-0250 Ext: 553 FTS: 8-782-7553
Alaska Area Native Health Service Alaska	Alaska Area Native Health Service Post Office Box 7-741 Anchorage, Alaska 99510	Ms. Norma Giles	Comm: 907-265-9397 FTS: 8-907-265-9397
Albuquerque Area IHS Colorado New Mexico	Albuquerque Area IHS Federal Office Building & U.S. Courthouse 500 Gold Avenue, S.W. Albuquerque, New Mexico 87102-0097	Mr. Gene McElyea	Comm: 505-766-1541 FTS: 8-474-1541
Bemidji Program Office IHS Illinois Indiana Michigan Minnesota Wisconsin	Bemidji Program Office IHS 203 Federal Building Bemidji, Minnesota 56601	Ms. Cindy Turner	Comm: 218-751-7701 FTS: 8-784-1701
Billings Area IHS Montana Wyoming	Billings Area IHS P.O. Box 2143 Billings, Montana 59103	Mr. Darrell Pratt	Comm: 406-657-6341 FTS: 8-585-6341

IHS AREA/PROGRAM OFFICE AND STATES/LOCALITY SERVED	ADDRESS OF AREA/PROGRAM	SCHOLARSHIP COORDINATOR	COMMERCIAL AND FTS TELEPHONE
California Program Office California Hawaii	California Program Office 2999 Fulton Avenue Sacramento, California 95821	Mr. Raymond Bobb	Comm: 916-484-4836 FTS: 8-468-4836
Navajo Area IHS Arizona New Mexico Utah	Navajo Area IHS P.O. Box G Window Rock, Arizona 86515	Mr. Bennie Yazzie	Comm: 602-871-5831 FTS: 8-572-8231
Oklahoma City Area IHS Kansas Missouri Oklahoma	Oklahoma City Area IHS 215 Dean A. McGee St., N.W. Oklahoma City, Oklahoma 73102-3477	Mr. Jim Ingram	Comm: 405-231-4448 FTS: 8-736-4448
Phoenix Area IHS Arizona Nevada Utah	Phoenix Area IHS 3738 N. 16th St., Suite A Phoenix, Arizona 85016-5981	Ms. Rosemary Foley	Comm: 602-241-2070 FTS: 8-261-2070
Portland Area IHS Idaho Oregon Washington	Portland Area IHS Federal Bldg., Rm 476 1220 S.W. Third Avenue Portland, Oregon 97204-2892	Ms. Darlene Marcelley	Comm: 503-221-2019 FTS: 8-423-2019
Tucson Program Office, IHS Arizona Texas	Tucson Area, IHS 7900 S. J. Stock Rd. Tucson, Arizona 85746	Ms. Eileen Preston	Comm: 602-629-6171 FTS: 8-762-6171

IHS AREA/PROGRAM OFFICE AND STATES/LOCALITY SERVED	ADDRESS OF AREA/PROGRAM	SCHOLARSHIP COORDINATOR	COMMERCIAL TELEPHONE
Nashville Program Office, IHS Arkansas Connecticut Delaware Florida Georgia Kentucky Louisiana Maryland Massachusetts Mississippi New Hampshire New Jersey New York North Carolina Ohio Pennsylvania Rhode Island South Carolina Tennessee Vermont Virginia West Virginia District of Columbia	Nashville Program Office, IHS Oaks Tower Building, Suite 810 1101 Kermit Drive Nashville, Tennessee 37217	Mr. Jesse Thomas	Comm: 615-251-5104 FTS: 8-852-5104

SPECIAL SCHOLARSHIP OFFICES AREAS SERVED	ADDRESS OF SPECIAL OFFICES	SCHOLARSHIP COORDINATOR	COMMERCIAL AND FTS TELEPHONE
Indians into Medicine (INMED) Students recruited by the INMED program only	Indians into Medicine (INMED) Univ. of North Dakota 501 N. Columbia Rd. Grand Forks, ND 58201	Dr. Lois Steele	Comm: 701-777-3037
Lumbee Regional Development Assoc. Members of the Lumbee Tribe only	Lumbee Regional Development Assoc. P.O. Box 68 Pembroke, North Carolina 28372	Ms. Belinda Harris	Comm: 919-521-8602

IHS HEADQUARTERS BRANCH CHIEF

The role of the IHS Headquarters Branch Chief of your particular health discipline is to monitor your academic performance to assure your success in your health education. The Branch Chief also assists Section 104 recipients with Extern Placement and with placement to begin and complete Service Obligation Payback. Please refer to the following listing of the Headquarters Branch Chiefs.

IHS HEADQUARTERS BRANCH CHIEF LISTING

Accounting/Computer Science

Mr. Dennis West
Executive Officer
Federal Building
500 Gold Ave., S.W.
Albuquerque, NM 87101-0097
(505) 766-2151

Alcoholism/Drug Abuse

Mr. Richard Zephier
Office of Alcoholism Program
Indian Health Service
Pueblo Cultural Center
2401 12th St., N.W.
Albuquerque, NM 87102
(8) 474-6590
(505) 766-6590

Audiology/Speech Pathology

Mr. Charles Lewis
P.O. Box 2143
Billings, MT 59103
(8) 585-6165
(406) 657-6165

Biomedical Engineering

Mr. David Sizemore
300 San Mateo N.E.
Suite 600
Albuquerque, NM 87101
(505) 474-6512

Biostatistics

Mr. Tony D'Angelo
Indian Health Service
5600 Fishers Lane, Room 6A-30
Rockville, MD 20857
(301) 443-1180

Dentistry

Dr. Gary Gritzbaugh
Indian Health Service
Dental Branch - Box 8978
300 San Mateo N.E.
Albuquerque, NM 87198
(8) 474-6500
(505) 766-6500

Dietetics/Nutrition

Ms. Yvonne Jackson
Indian Health Service
Parklawn Bldg., Room 5A-10
5600 Fishers Lane
Rockville, MD 20857
(301) 443-1114

Environmental Health - Engineering	Mr. Gary Hartz Indian Health Service Parklawn Bldg., Room 6A-46 5600 Fishers Lane Rockville, MD 20857 (301) 443-1046
Environmental Health Services	Mr. John Dieteman Indian Health Service Parklawn Bldg., Room 6A-48 5600 Fishers Lane Rockville, MD 20857 (301) 443-1046
Health Education	Mr. Marland Koomsa Indian Health Service Parklawn Bldg., Room 5A-07 5600 Fishers Lane Rockville, MD 20857 (301) 443-1870
Health Care Administration	Mr. Garth Hinderman Indian Health Service Parklawn Bldg., Room 5A-39 5600 Fishers Lane Rockville, MD 20857 (301) 443-5620
Medical Records	Dr. Robert Kreuzburg, Acting Indian Health Service Parklawn Bldg., Room 6A-55 5600 Fishers Lane Rockville, MD 20857 (301) 443-3024
Medical Technology	Ms. Linda Meacher Indian Health Service Parklawn Bldg., Room 5A-03 5600 Fishers Lane Rockville, MD 20857 (301) 443-4680
Mental Health	Dr. William Hunter (Acting) Indian Health Service 2401 12th St., N.W. Albuquerque, NM 87102 (8) 474-2873 (505) 766-2873

Nursing	Ms. Sylvia Rhodes Indian Health Service Parklawn Bldg., Room 5A-09 5600 Fishers Lane Rockville, MD 20857 (301) 443-1840
Occupational Therapy	Mr. Albert Esparsen U.S. Public Health Service (DHHS-IHS) Indian Hospital 1700 Cerrillos Road Santa Fe, NM 87501
Optometry	Dr. Siu Wong Albuquerque Area Federal Building 115 4th Ave., S.E. Albuquerque, NM 87101 (8) 474-1537 (605) 474-2159
Paramedic	Mr. Jerry Rousseau Indian Health Service 4122 N. 16th St. Phoenix, az 85016 (602) 241-2611
Pharmacy	Mr. Richard Church Indian Health Service Parklawn Bldg., Room 5A-03 5600 Fishers Lane Rockville, MD 20857 (301) 443-1830
Physical Therapy	Mr. Dale Swett Gallup Indian Medical Center P.O. Box 1357 Gallup, NM 87301 (8) 571-1529 (505) 722-1000
Physicians Assistant/Associate	Dr. Leland Fairbanks Phoenix Area IHS 4212 N. 16th St. Phoenix, AZ 85016 (8) 762-1200 (602) 263-1200
Pre-Med/Medicine	Dr. John Gimon Indian Health Service Parklawn Bldg., Room 6A-53 5600 Fishers Lane Rockville, MD 20857 (301) 443-4243

Radiologic Technology	Dr. Jackson Saxon Office of Research and Development Indian Health Service P.O. Box 11340 Tucson, AZ 85734 (8) 762-6858 (602) 792-6911
Social Work	Dr. John Richardson Deputy Chief, Medical Social Services Navajo Area IHS P.O. Box G Window Rock, AZ 86515 (8) 572-8243
Veterinary Medicine	Mr. Rick Smith Indian Health Service Parklawn Bldg., Room 6A-08 5600 Fishers Lane Rockville, MD 20857 (301) 443-4644

PERSONNEL INVOLVED WITH THE SCHOLARSHIP

GRANTS MANAGEMENT OFFICER

The Grants Management Officer, IHS, is Ms. M. Kay Carpentier, Parklawn Building, Room 6A-29, 5600 Fishers Lane, Rockville, Maryland 20857; telephone number (301) 443-5204. The role of the Grants Officer is to complement the programmatic knowledge of the Title I Manager and the Area/Program Scholarship Coordinator with expertise in administrative and non-programmatic areas such as issuance of grant awards and coordination of payments for tuition, travel, and stipends.

TITLE I MANAGER

The Title I Manager, IHS, is Mr. Pierre Colombel, Parklawn Building, Room 6A-23, 5600 Fishers Lane, Rockville, Maryland 20857; telephone number (301) 443-5440. The Title I Manager is responsible for all programmatic asspects of the five sections for P.L. 94-437, Title I. Additionally, the Title I Manager serves as the authority on programmatic issues and decisions.

HEADQUARTERS SCHOLARSHIP COORDINATOR

Headquarters Scholarship Coordinator, Mr. Larry Thomas, is responsible for the coordination of the programmatic aspects of the Title I programs and the activities of the Area/Program Scholarship Coordinators. Mr. Thomas is located in the Parklawn Building, 5600 Fishers Lane, Room 6A-23, Rockville, MD 20857, telephone (301) 443-5440.

SERVICES OBLIGATION COORDINATOR

The Service Obligation Coordinator, Mr. John Gimon, is responsible for assisting with the service obligation placement process for IHS scholarship graduates. To do so, he coordinates placement efforts with the Headquarters Branch Chiefs and tracks the placement process. Mr. Gimon is located in the Parklawn Building, 5600 Fishers Lane, Room 6A-53, Rockville, MD 20857, telephone (301) 443-4243.

BENEFITS OF THE SCHOLARSHIP

SECTION C

BENEFITS OF THE SCHOLARSHIP

TUITION AND REQUIRED FEES

The IHS Office, Rockville, Maryland arranges payment of all tuition and other mandatory fees, such as laboratory fees, upon receipt of a bill from your educational institution. The tuition amount, 11J of the Notice of Grant Award, is only an estimate; it will be revised to cover all tuition costs as billed by the college or university. Payment of tuition and fees is made directly to the educational institution.

The scholarship program will pay for tuition and fees directly applicable to the student's approved curriculum and program. Payment will not be made for tuition and fee items unrelated to the approved program, e.g., membership dues for student societies, associations, and similar expenses, or for school terms that begin prior to the beginning date of the scholarship award or after the expiration date of the scholarship award.

The IHS will not pay tuition, fees, and other costs for summer school unless you have requested and received prior approval. Specific instructions regarding appropriate procedures for requesting approval are contained on page G-03 of this Handbook.

UNIVERSITY REIMBURSEMENT FOR TUITION AND FEES

You are not responsible for paying your tuition and fees. The IHS does this; however, you should be aware of the process. The IHS billing instructions for universities regarding payment for your tuition and fees follow.

University/College Financial Office:

The student whose Notice of Grant Award (NOGA) is attached has been awarded a scholarship grant for the 1985-1986 school year from the Indian Health Service (IHS), Department of Health and Human Services, under the authority of P.L. 94-437, The Indian Health Care Improvement Act, Title I, Indian Health Manpower. This NOGA is the official legal notification of the student grant. Additionally, the scholarship budget and the total amount of the award are listed on the first page.

The IHS will pay tuition and all mandatory fees directly to the university/college upon receipt of a properly submitted university/college invoice. Note that the amount listed for tuition on the NOGA is only an estimate and will be adjusted as necessary to pay the full invoice amount. This estimated amount is for Fall, Winter, and Spring sessions only. The IHS will pay summer school tuition ONLY if the student has requested and received prior written approval from the IHS to attend summer sessions.

Follow these instructions carefully to avoid payment problems. Please send all invoices to:

Indian Health Service
ATTN: Grants Management
Parklawn Building, Room 6A-29
5600 Fishers Lane
Rockville, Maryland 20857

The IHS can assure expedited payment of tuition and fees if you submit a separate invoice for each student which contains the following information:

(1) university/college invoice number,
(2) name of student,
(3) amount of tuition and itemized fees,
(4) period for which tuition and fees apply, and
(5) the student's grant number which appears as Item 4 on the NOGA, e.g., ISF001234.

Payment delays result when any of these items are missing.

NOTE: PLEASE SUBMIT A SEPARATE INVOICE FOR EACH STUDENT. AN INVOICE WHICH CONTAINS MULTIPLE NAMES WILL DELAY PAYMENT.

The IHS pays directly to the student a stipend of $577 per month which is to cover room, board, and personal expenses. Thus, the IHS will not pay dormitory and meal costs. The student is responsible for payment of these expenses.

Each student also receives a lump sum payment at the beginning of each scholarship year to pay for: (1) books (Fall/Winter/Spring sessions), (2) miscellaneous costs, and (3) travel for one round trip to and from the university/college. The student is responsible for payment of all books, equipment, and supplies. The IHS will not pay invoices from the university/college bookstore.

If you encounter any problems with the payment of invoices or if you have questions, please call the grants office at (301) 443-5204 and the grants staff will assist you.

It is our sincere hope that the student's academic experience with your institution will be rewarding and our professional association pleasant.

Sincerely,

M. Kay Carpentier

M. Kay Carpentier
Grants Management Officer
Indian Health Service

Attachment

BENEFITS OF THE SCHOLARSHIP

STIPEND FOR STUDENT LIVING EXPENSES

During the 1985-1986 school year, the IHS scholarship program will pay a stipend of $577.00 at the beginning of each month for living expenses to include room and board. The first stipend check for the new school year will be mailed about August 15.

Awardees for Section 103 and 103P will receive a stipend only for the academic period covered by their awards - August 1 to May 31. A stipend for the months of June and July will be paid only to those 103 and 103P students who have requested and been approved in advance to attend summer sessions.

Awardees for Section 104 will receive a stipend for a twelve-month period beginning August 1 through July 31.

ADDRESS FOR STIPEND CHECK RECEIPT

You must either establish an account with a bank, credit union, or savings and loan for DIRECT DEPOSIT of the stipend to your account OR obtain a post office box to serve as your stipend receipt address for the period of the grant award. Federal Treasury checks cannot be forward. If you have arranged for direct deposit, you must also submit Form 1199A, Department of Treasury Authorization of Federal Recurring Payment, which is available from your bank or financial institution or from your Area/Program Scholarship Coordinator.

THIS STIPEND RECEIPT ADDRESS WILL NOT BE CHANGED DURING THE ENTIRE 1985-86 YEAR OF SCHOLARSHIP FUNDING. You will not be allowed to change this address unless you change schools and relocate to another city.

Since Federal checks cannot be forwarded, this requirement is necessary to prevent delay and/or loss of stipend checks. Previous scholarship recipients have encountered delays of up to eight weeks in receiving their stipend checks when addresses have been changed.

BENEFITS OF THE SCHOLARSHIP

BOOKS, MISCELLANEOUS EDUCATIONAL EXPENSES, AND TRAVEL

The first check contains money for books, miscellaneous educational expenses, travel for the Fall, Winter, and Spring terms, and includes $25.00 for post office box rental for receiving the monthly stipend check. You must pay for all books. IHS does not pay school bookstore invoices. It is your responsibility to obtain health insurance, and you are URGED to enroll in a good school health plan. Funds to pay at least part of the costs of health insurance are included in miscellaneous education expenses. The travel advance is for ONE round-trip to school and return via private car, bus, etc., for the entire school year. You will not be reimbursed for moving expenses and daily mileage to and from school.

The scholarship program will not pay for any additional expenses incurred by the recipient over the lump sum amount unless the expense is specifically required by the school and adequate documentation is submitted. An example of an allowable expense is dental equipment. If you are enrolled in the health discipline and submit an itemized listing of the dental equipment you must have under the program, the IHS will pay for the equipment. However, your request must be countersigned by your academic advisor and verified as being mandatory for your program.

SUMMARY OF BENEFITS

Stipend	$ 577.00	
Travel	200.00	
Miscellaneous Health Insurance Post Office Box	75.00	
Books/Supplies	325.00	$ 600.00 for students in medical school only
Tuition	Varies according to educational institution	

BENEFITS OF THE SCHOLARSHIP

ACCEPTANCE OF OTHER FEDERAL BENEFITS

VETERANS BENEFITS

Education benefits from the Veterans Administration (G.I. Bill) may continue along with the IHS scholarship program funds since these VA benefits were earned by prior active duty in a uniformed service.

BENEFITS FROM OTHER FEDERAL PROGRAMS

The IHS will not award a scholarship to any student who is receiving other Federal funds in the form of scholarships, loans, or grants, e.g., funding from the Bureau of Indian Affairs and loans from the Department of Education. Current employees of any Federal government agency are also ineligible for scholarship funding.

LOST STIPEND CHECKS

SECTION D

LOST STIPEND CHECKS

LOST CHECKS

Your first check should reach you by August 15 and no later than the first of each month thereafter. If you do not receive your check by the 5th of the month, immediately submit the following letter and explain why the check was not received.

The letter initiates tracing action on the check. If the check is returned to the Treasury Department it will be reissued within two weeks of return. If the check is lost, it may take up to eight weeks for the Treasury Department to reissue the check.

Changes of address are the primary reason for missing and lost checks. To prevent the delay and inconvenience of a missing check, IHS stresses use of either direct deposit or a post office box for receipt of your stipend check.

Indian Health Service
Grants Management Section
Attention: Dorothy Harjo
Parklawn Building, Room 6A-29
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Harjo:

I did not receive my stipend check in the amount of $_____ for the month
amount
of _____. I believe the check was not received for the
month
following reason:_____

_____

Please trace and reissue as soon as possible.

Name:_____

Address:_____

_____

Telephone No.:_____

IHS Grant No.:_____

_____
Signature (DO NOT PRINT)

Indian Health Service
Grants Management Section
Attention: Dorothy Harjo
Parklawn Building, Room 6A-29
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Harjo:

I did not receive my stipend check in the amount of $_____ for the month
(amount)
of _____. I believe the check was not received for the
(month)
following reason:_____

_____

Please trace and reissue as soon as possible.

Name:_____

Address:_____

_____

Telephone No.:_____

IHS Grant No.:_____

_____
Signature (DO NOT PRINT)

Indian Health Service
Grants Management Section
Attention: Dorothy Harjo
Parklawn Building, Room 6A-29
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Harjo:

I did not receive my stipend check in the amount of $_____ for the month
amount
of _____. I believe the check was not received for the
month
following reason:_____

_____

Please trace and reissue as soon as possible.

Name:_____

Address:_____

_____

Telephone No.:_____

IHS Grant No.:_____

_____
Signature (DO NOT PRINT)

ACADEMIC REQUIREMENTS

OF THE

SCHOLARSHIP RECIPIENT

SECTION E

ACADEMIC REQUIREMENTS OF THE SCHOLARSHIP RECIPIENT

It is the policy of the Indian Health Service (IHS) that a recipient of a scholarship awarded under Section 103 or 104 of the Indian Health Care Improvement Act must maintain a 2.0 cumulative grade point average and must be a full-time student (minimum of 12 credit hours). A grantee receiving a scholarship under the Section 103 Pregraduate Scholarship authority must maintain a 2.5 cumulative grade point average to be eligible for continuation and maintain a full-time course load. A section 104 grantee must also be enrolled in an approved/accredited school for a health profession.

Grantees who comply with these requirements are eligible for continued scholarship support beyond the budget period listed in item number 7 of the NOGA and in accordance with the provisions of the Act.

TERMINATION OF SCHOLARSHIP OR SUSPENSION OF BENEFITS

A leave of absence will not be granted. Scholarship support will be terminated if a student withdraws from school for any reason. For reinstatement, you must apply and compete as a new applicant during the regular scholarship cycle.

SCHOLARSHIP

REPORTING REQUIREMENTS

SECTION F

SCHOLARSHIP REPORTING REQUIREMENTS

The following reports and documents must be sent to the IHS Area/Program Office Scholarship Coordinator identified in item 10 of the Notice of Grant Award. IF YOU FAIL TO SUBMIT THE REPORTS AS REQUIRED YOU WILL BE INELIGIBLE FOR CONTINUATION OF SCHOLARSHIP SUPPORT AND YOUR AWARD WILL BE TERMINATED.

RECIPIENT'S ENROLLMENT AND INITIAL PROGRAM PROGRESS REPORT

Within thirty days from the beginning of each semester or quarter, you must submit an Initial Progress Report (p. F-02 of this Handbook), signed by your school advisor or the registrar's office verifying that you are enrolled in a full-time course load for the semester/quarter. A full-time course load is a minimum of 12 credit hours or the number of credit hours considered by your school as full-time. You must also submit a curriculum outline, approved by your advisor, for your chosen health program.

OMB Approved No. 0915-0080

F-02

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Recipient's Enrollment and Initial Program Progress Report

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: Semester Quarter

CLASS ENROLLMENT - List the courses in which you are currently enrolled if you do not have an official university printout to attach to this report.

COURSE NUMBER	TITLE	HOURS

DURING THIS REPORT PERIOD I WILL PARTICIPATE IN THE FOLLOWING SPECIAL ACTIVITIES IN MY SCHOOL OR COMMUNITY: _____

DURING THIS REPORT PERIOD I HAVE ENCOUNTERED THE FOLLOWING PROBLEMS WITH MY SCHOOL, COMMUNITY OR SCHOLARSHIP: _____

MAJOR ACTIVITIES WHICH WILL AFFECT ME IN THE COMING MONTHS ARE: _____

ADDITIONAL COMMENTS: _____

STUDENT'S SIGNATURE _____ DATE _____

ADVISOR'S SIGNATURE AND TITLE _____ DATE _____

ADVISOR'S ADDRESS _____ ADVISOR'S TELEPHONE NUMBER _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE REVIEWED _____

OMB Approved No. 0915-0080

P-02

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Recipient's Enrollment and Initial Program Progress Report

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: Semester Quarter

CLASS ENROLLMENT - List the courses in which you are currently enrolled if you do not have an official university printout to attach to this report.

COURSE NUMBER	TITLE	HOURS

DURING THIS REPORT PERIOD I WILL PARTICIPATE IN THE FOLLOWING SPECIAL ACTIVITIES IN MY SCHOOL OR COMMUNITY: _____

DURING THIS REPORT PERIOD I HAVE ENCOUNTERED THE FOLLOWING PROBLEMS WITH MY SCHOOL, COMMUNITY OR SCHOLARSHIP: _____

MAJOR ACTIVITIES WHICH WILL AFFECT ME IN THE COMING MONTHS ARE: _____

ADDITIONAL COMMENTS: _____

STUDENT'S SIGNATURE _____ DATE _____

ADVISOR'S SIGNATURE AND TITLE _____ DATE _____

ADVISOR'S ADDRESS _____ ADVISOR'S TELEPHONE NUMBER _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE REVIEWED _____

OMB Approved No. 0915-0080

F-02

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Recipient's Enrollment and Initial Program Progress Report

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: Semester Quarter

CLASS ENROLLMENT - List the courses in which you are currently enrolled if you do not have an official university printout to attach to this report.

COURSE NUMBER	TITLE	HOURS

DURING THIS REPORT PERIOD I WILL PARTICIPATE IN THE FOLLOWING SPECIAL ACTIVITIES IN MY SCHOOL OR COMMUNITY: _____

DURING THIS REPORT PERIOD I HAVE ENCOUNTERED THE FOLLOWING PROBLEMS WITH MY SCHOOL, COMMUNITY OR SCHOLARSHIP: _____

MAJOR ACTIVITIES WHICH WILL AFFECT ME IN THE COMING MONTHS ARE: _____

ADDITIONAL COMMENTS: _____

STUDENT'S SIGNATURE _____ DATE _____

ADVISOR'S SIGNATURE AND TITLE _____ DATE _____

ADVISOR'S ADDRESS _____ ADVISOR'S TELEPHONE NUMBER _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE REVIEWED _____

OMB Approved No. 0915-0080 F-02

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Recipient's Enrollment and Initial Program Progress Report

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: Semester Quarter

CLASS ENROLLMENT - List the courses in which you are currently enrolled if you do not have an official university printout to attach to this report.

COURSE NUMBER	TITLE	HOURS

DURING THIS REPORT PERIOD I WILL PARTICIPATE IN THE FOLLOWING SPECIAL ACTIVITIES IN MY SCHOOL OR COMMUNITY: _____

DURING THIS REPORT PERIOD I HAVE ENCOUNTERED THE FOLLOWING PROBLEMS WITH MY SCHOOL, COMMUNITY OR SCHOLARSHIP: _____

MAJOR ACTIVITIES WHICH WILL AFFECT ME IN THE COMING MONTHS ARE: _____

ADDITIONAL COMMENTS: _____

STUDENT'S SIGNATURE _____ DATE _____

ADVISOR'S SIGNATURE AND TITLE _____ DATE _____

ADVISOR'S ADDRESS _____ ADVISOR'S TELEPHONE NUMBER _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE REVIEWED _____

SCHOLARSHIP REPORTING REQUIREMENTS

TRANSCRIPTS

Within 30 days from the end of each academic period, i.e., semester, quarter, or summer session, submit an OFFICIAL transcript for the academic period completed to your Area/Program Scholarship Coordinator.

SCHOLARSHIP REPORTING REQUIREMENTS

NOTIFICATION OF ACADEMIC PROBLEM/CHANGE

If at any time during the semester/quarter you reduce the number of credit hours for which you are enrolled below the minimum of 12, or if you experience academic problems, you must submit this report to the Area/Program Scholarship Coordinator. See page F-05 for form.

If you are enrolled in at least 12 credit hours and are doing satisfactorily in all classes (at least a "C" or better), you do not have to submit this report. However, if you are doing satisfactorily but you are having special problems, you may use this form to alert your coordinator of these problems and request assistance, e.g., tutorial service or approval to drop a course.

OMB Approved No. 0915-0080

F-05

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Notification of Academic Problem/Change

If you experience any academic problems, are placed on academic probation, or fall below the minimum full-time course curriculum of 12 credit hours you must submit this report. DO NOT SUBMIT THIS REPORT IF YOU ARE ENROLLED IN AT LEAST 12 CREDIT HOURS AND ARE PERFORMING SATISFACTORILY (at least a "C" or better), IN ALL CLASSES.

_____ NAME OF RECIPIENT

_____ HEALTH DISCIPLINE

_____ GRANT NUMBER

_____ NAME OF EDUCATIONAL INSTITUTION

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: ____SEMESTER ___QUARTER

INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU:
_____I AM CURRENTLY ENROLLED IN THE MINIMUM REQUIREMENT OF 12 CREDIT HOURS BUT HAVING PROBLEMS.
_____I HAVE BEEN PLACED ON ACADEMIC PROBATION.
_____I HAVE DROPPED COURSES WITH RECOMMENDATION AND APPROVAL OF MY ADVISOR.
_____Previous Enrolled Credit Hours _____Current Enrolled Credit Hours

DESCRIPTION OF PROBLEM:_____

LIST BY COURSE NUMBER, TITLE, AND HOURS THE COURSES YOU ARE HAVING PROBLEMS IN:_____

DESCRIBE YOUR PROPOSED ACTION (i.e., obtain tutor assistance, seek no assistance and withdraw or terminate, etc.):_____

_____ STUDENT'S SIGNATURE

_____ DATE

_____ ADVISOR'S SIGNATURE

_____ DATE

_____ SCHOLARSHIP COORDINATOR'S SIGNATURE

_____ DATE REVIEWED

_____ BRANCH CHIEF'S SIGNATURE

_____ DATE REVIEWED

OMB Approved No. 0915-0080 F-05

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Notification of Academic Problem/Change

If you experience any academic problems, are placed on academic probation, or fall below the minimum full-time course curriculum of 12 credit hours you must submit this report. DO NOT SUBMIT THIS REPORT IF YOU ARE ENROLLED IN AT LEAST 12 CREDIT HOURS AND ARE PERFORMING SATISFACTORILY (at least a "C" or better), IN ALL CLASSES.

_____ NAME OF RECIPIENT

_____ HEALTH DISCIPLINE

_____ GRANT NUMBER

_____ NAME OF EDUCATIONAL INSTITUTION

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: ____SEMESTER ___QUARTER

INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU:
_____I AM CURRENTLY ENROLLED IN THE MINIMUM REQUIREMENT OF 12 CREDIT HOURS BUT HAVING PROBLEMS.
_____I HAVE BEEN PLACED ON ACADEMIC PROBATION.
_____I HAVE DROPPED COURSES WITH RECOMMENDATION AND APPROVAL OF MY ADVISOR.
_____Previous Enrolled Credit Hours _____Current Enrolled Credit Hours

DESCRIPTION OF PROBLEM:_____

LIST BY COURSE NUMBER, TITLE, AND HOURS THE COURSES YOU ARE HAVING PROBLEMS IN:

DESCRIBE YOUR PROPOSED ACTION (i.e., obtain tutor assistance, seek no assistance and withdraw or terminate, etc.):_____

_____ STUDENT'S SIGNATURE

_____ DATE

_____ ADVISOR'S SIGNATURE

_____ DATE

_____ SCHOLARSHIP COORDINATOR'S SIGNATURE

_____ DATE REVIEWED

_____ BRANCH CHIEF'S SIGNATURE

_____ DATE REVIEWED

OMB Approved No. 0915-0080 F-05

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Notification of Academic Problem/Change

If you experience any academic problems, are placed on academic probation, or fall below the minimum full-time course curriculum of 12 credit hours you must submit this report. DO NOT SUBMIT THIS REPORT IF YOU ARE ENROLLED IN AT LEAST 12 CREDIT HOURS AND ARE PERFORMING SATISFACTORILY (at least a "C" or better), IN ALL CLASSES.

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: ____SEMESTER ___QUARTER

INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU:
_____I AM CURRENTLY ENROLLED IN THE MINIMUM REQUIREMENT OF 12 CREDIT HOURS BUT HAVING PROBLEMS.
_____I HAVE BEEN PLACED ON ACADEMIC PROBATION.
_____I HAVE DROPPED COURSES WITH RECOMMENDATION AND APPROVAL OF MY ADVISOR.
_____Previous Enrolled Credit Hours _____Current Enrolled Credit Hours

DESCRIPTION OF PROBLEM:_____

LIST BY COURSE NUMBER, TITLE, AND HOURS THE COURSES YOU ARE HAVING PROBLEMS IN:

DESCRIBE YOUR PROPOSED ACTION (i.e., obtain tutor assistance, seek no assistance and withdraw or terminate, etc.):_____

STUDENT'S SIGNATURE _____ DATE _____

ADVISOR'S SIGNATURE _____ DATE _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE REVIEWED _____

BRANCH CHIEF'S SIGNATURE _____ DATE REVIEWED _____

F-05

OMB Approved No. 0915-0080

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Notification of Academic Problem/Change

If you experience any academic problems, are placed on academic probation, or fall below the minimum full-time course curriculum of 12 credit hours you must submit this report. DO NOT SUBMIT THIS REPORT IF YOU ARE ENROLLED IN AT LEAST 12 CREDIT HOURS AND ARE PERFORMING SATISFACTORILY (at least a "C" or better), IN ALL CLASSES.

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: ____SEMESTER ___QUARTER

INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU:
_____I AM CURRENTLY ENROLLED IN THE MINIMUM REQUIREMENT OF 12 CREDIT HOURS BUT HAVING PROBLEMS.
_____I HAVE BEEN PLACED ON ACADEMIC PROBATION.
_____I HAVE DROPPED COURSES WITH RECOMMENDATION AND APPROVAL OF MY ADVISOR.
_____Previous Enrolled Credit Hours _____Current Enrolled Credit Hours

DESCRIPTION OF PROBLEM:_____

LIST BY COURSE NUMBER, TITLE, AND HOURS THE COURSES YOU ARE HAVING PROBLEMS IN:_____

DESCRIBE YOUR PROPOSED ACTION (i.e., obtain tutor assistance, seek no assistance and withdraw or terminate, etc.):_____

STUDENT'S SIGNATURE _____ DATE _____

ADVISOR'S SIGNATURE _____ DATE _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE REVIEWED _____

BRANCH CHIEF'S SIGNATURE _____ DATE REVIEWED _____

CHANGE OF STATUS

ACADEMIC PROBATION

You must notify your Area/Program Scholarship Coordinator immediately if you are placed on academic probation. Such notification will alert your coordinator that you need special assistance such as tutorial services or reduction of course load. The coordinator will advise you on alternatives that may help you.

WITHDRAWAL FROM SCHOOL

If you are considering voluntarily withdrawing from school for any reason (personal or medical), you should inform your Area Scholarship Coordinator prior to actually dropping your classes. Your coordinator may be able to advise you of alternative courses of action that will allow you to continue in the scholarship program. If you do withdraw from school, your coordinator must be notified immediately in order to stop your stipend checks. If you fail to notify IHS and you continue to cash stipend checks, you will be liable for return of all funds to which you were not entitled.

DISMISSAL FROM SCHOOL

You must notify your Area/Program Scholarship Coordinator immediately if you are dismissed from school. If you fail to notify IHS and you continue to cash stipend checks, you will be liable for return of all funds to which you were not entitled.

CHANGE OF MAJOR

You may not change from the approved major listed in item 8 of the NOGA major during a school year. If you make an unapproved change, you will be dropped from the scholarship program.

If you wish to change majors, you must do so when you apply for continuation of your scholarship. The major to which you are changing must be one of the IHS priority categories listed for the new scholarship cycle. Also, you must apply and recompete as a new applicant.

In addition to information required for all new applicants, submit documentation to verify the number of hours earned and transferable from your current program major into the new major you are requesting.

CHANGE OF STATUS

SCHOOL TRANSFER REQUEST

At least 30 days prior to the time of transfer from the school cited on the NOGA, you must request approval for the change. State clearly the reason for the transfer.

You may request a transfer of schools during the school year for only two (2) reasons:

1. To change from a school with a nonaccredited program in your health discipline to a school with an accredited program, and

2. To change from a school that does not offer courses required for your health professions degree to a school offering the necessary courses.

Personal and/or family hardships which may necessitate school transfer will be considered on an individual basis.

You must submit a school acceptance letter which specifies entry into a specific health professions program with your request. Also submit documentation to verify the number of hours earned and transferable from your current school to the school you are requesting to attend.

You will be notified of the IHS's approval/disapproval of the request. <u>If you change schools without prior approval of the IHS, you will be dropped from the scholarship program</u>.

CHANGE IN GRADUATION DATE

At any time that a change occurs in your expected graduation date, notify your Area/Program Scholarship Coordinator.

PROGRAM CHANGE

Provide supportive documentation when requesting change from Section 103 to 104 (letter of acceptance from your chosen health professional program) or from 104 to 103 (verification that you are enrolled in preparatory courses and a copy of your proposed curriculum).

TUTORIAL ASSISTANCE OR

SUMMER SCHOOL REQUEST

SECTION G

REQUEST FOR TUTORIAL ASSISTANCE

The IHS wants to assist you in getting the maximum benefit from your education. Therefore, if you have difficulty with one or more courses, you may participate in special classes or arrange for tutorial assistance to correct the difficulty and improve your academic performance. Submit the Request for Tutorial Assistance Form on page G-02 to your Area/Program Scholarship Coordinator.

You are also encouraged to use tutorial services to improve your grades even if they are satisfactory and/or to address special educational problems such as a weakness in English or math which may be affecting your overall academic performance. Again, submit the form on page G-02.

G-02

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Request for Tutorial Assistance

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTUTITION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: Semester Quarter

I AM CURRENTLY PERFORMING UNSATISFACTORILY IN THE FOLLOWING COURSE(S):

COURSE NUMBER	TITLE	HOURS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIFIC DESCRIPTION OF PROBLEMS: _____

DESCRIBE TUTOR ASSISTANCE NEEDED: _____

T U T O R I A L R E Q U E S T

NAME(S) OF TUTOR(S): _____
TUTOR(S) QUALIFICATIONS: _____

T U T O R S C H E D U L E

Number of hours	Rate per Hour	Total Cost
_____	_____	_____
_____	_____	_____
_____	_____	_____

STUDENT'S SIGNATURE _____ Date _____

ADVISOR'S SIGNATURE _____ DATE _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE _____

GRANTS MANAGEMENT OFFICER _____ DATE _____

G-02

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Request for Tutorial Assistance

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTUTITION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: Semester Quarter

I AM CURRENTLY PERFORMING UNSATISFACTORILY IN THE FOLLOWING COURSE(S):

COURSE NUMBER	TITLE	HOURS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIFIC DESCRIPTION OF PROBLEMS: _____

DESCRIBE TUTOR ASSISTANCE NEEDED: _____

T U T O R I A L R E Q U E S T

NAME(S) OF TUTOR(S): _____
TUTOR(S) QUALIFICATIONS: _____

T U T O R S C H E D U L E

Number of hours	Rate per Hour	Total Cost
_____	_____	_____
_____	_____	_____
_____	_____	_____

STUDENT'S SIGNATURE _____ Date _____

ADVISOR'S SIGNATURE _____ DATE _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE _____

GRANTS MANAGEMENT OFFICER _____ DATE _____

G-02

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Request for Tutorial Assistance

NAME OF RECIPIENT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTUTITION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CIRCLE ONE: Fall Winter Spring Summer INDICATE ONE: Semester Quarter

I AM CURRENTLY PERFORMING UNSATISFACTORILY IN THE FOLLOWING COURSE(S):

COURSE NUMBER	TITLE	HOURS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIFIC DESCRIPTION OF PROBLEMS: _____

DESCRIBE TUTOR ASSISTANCE NEEDED: _____

T U T O R I A L R E Q U E S T

NAME(S) OF TUTOR(S): _____
TUTOR(S) QUALIFICATIONS: _____

T U T O R S C H E D U L E

Number of hours	Rate per Hour	Total Cost
_____	_____	_____
_____	_____	_____
_____	_____	_____

STUDENT'S SIGNATURE _____ Date _____

ADVISOR'S SIGNATURE _____ DATE _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE _____

GRANTS MANAGEMENT OFFICER _____ DATE _____

SUMMER SCHOOL

Students may need to take summer courses to graduate; to complete course requirements necessary either for graduation within the four year maximum time period provided by the Section 104 scholarship program or for earlier acceptance into a health professions program; or to retake courses that were not satisfactorily completed.

A summer school funding request must be received in your IHS Scholarship Coordinator's office by April 1.

In order to apply for summer school, complete the Summer School Request form on page G-04. Have your school advisor sign the form and provide documentation substantiating the need for the courses you have listed. Documentation may be a curriculum listing for your program or a statement from your advisor verifying that the requested courses are needed for your program. Summer course(s) must be required by your academic program. Summer school will not be approved for optional courses are not related to your academic program.

Summer school costs will be paid only if you apply in advance and if you receive prior approval from your Branch Chief. If you do receive prior approval, all summer school tuition, fees, and book expenses will be paid.

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

G-04

Summer School Request

NAME OF APPLICANT _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

TYPE OF PROGRAM: ____Sec. 103 Health Preparatory ____Section 103P Pregraduate
____Sec. 104 Health Profession

CLEARLY AND SPECIFICALLY DEFINE THE PURPOSE OF YOUR REQUEST FOR APPROVAL TO ATTEND SUMMER SCHOOL: _____

P R O P O S E D S E S S I O N (S) A N D C O U R S E (S)

SUMMER SESSION I DATES: FROM _____ TO _____

Course Number	Title	HOURS
_____	_____	_____
_____	_____	_____

SUMMER SESSION II DATES: FROM _____ TO _____

Course Number	Title	Hours
_____	_____	_____
_____	_____	_____

YOU MUST SUBMIT DOCUMENTATION TO SUBSTANTIATE THESE COURSE REQUIREMENTS.

F U N D I N G R E Q U E S T E D

	SUMMER SESSION I	SUMMER SESSION II	SUMMER TOTAL
Tuition	_____	_____	_____
Fees	_____	_____	_____
Books	_____	_____	_____
Total	_____	_____	_____

APPLICANT'S SIGNATURE _____ DATE _____

ADVISOR'S SIGNATURE _____ DATE _____

SCHOLARSHIP COORDINATOR'S SIGNATURE _____ DATE _____

EXTERN PROGRAM FOR SECTION 104

SECTION H

EXTERN PROGRAM FOR HEALTH PROFESSIONS SCHOLARSHIP SECTION 104

Individuals receiving Section 104 scholarships and not graduating this academic year are entitled to employment by the IHS as an Extern. Extern Assignments are available during the period of May - September of each year. You will be assigned to an IHS facility where you will participate in a full range of activities in your health profession. You will gain practical experience while applying the knowledge and skills you obtained in school.

ELIGIBILITY

Externships are approved if you are in an undergraduate school and have a 2.0 grade point average or are in graduate school and have a 3.0 grade point average, and have not been discontinued for any reason.

Section 104 scholarship recipients who will be graduating this academic year are not eligible for the extern program.

APPLICATION

Section 104 students must submit a complete application consisting of:

1. Personal Qualifications Statement - Standard Form 171 - See Appendix
2. Extern Site Preference Request,
3. Inclusive College Transcripts, and
4. Request for Extern Travel Reimbursement

APPLICATION DUE DATE

Complete, signed and dated applications must be received before close of business on the deadline date of FEBRUARY 1, or must be clearly postmarked by no later than midnight on January 29, and addressed to your IHS Area/Program Scholarship Coordinator, Attention: Extern Program Coordinator.

BENEFITS UNDER THE EXTERN PROGRAM

1. Tuition or Salary (NOT BOTH)

    a. If you use the summer experience to fulfill a required field placement experience or an internship requirement under your health profession education program, the IHS will pay your school tuition and fees but will not pay an externship salary.

best copy available

b. If you choose to accept externship pay for the summer field placement experience then IHS will not pay the school tuition for you to complete the field placement or internship requirement under your health profession education program. You must pay tuition and all fees.

c. Amount of Externship Salary

Participants in the Extern Program will receive payment for services comparable to the salary they would receive if they were employed in the competitive Federal service. Salary is based on the number of semester hours which the student has completed in his/her academic program:

GS-2	30 semester hours
GS-3	60 semester hours
GS-4	90 semester hours
GS-5	Bachelors
GS-6	1st year of graduate school
GS-7	2nd year of graduate school

2. Travel

You will receive a lump sum payment for one round trip to your Extern site IF you request travel reimbursement. You may request and receive the travel funds prior to the extern travel or upon completion of the Extern travel. In either case you must submit the Request for Extern Travel Reimbursement.

OMB APPROVED: No. 0915-0080 H-03

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Extern Site Preference Request

APPLICANT'S NAME _____ GRANT NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

AREA CODE AND TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

HEALTH PROFESSION CURRENTLY ENROLLED IN: _____

PROJECTED GRADUATION DATE: _____ CURRENT GPA: _____

TYPE OF DEGREE TO BE CONFERRED: _____

NAME OF UNIVERSITY: _____

DO YOU PLAN TO CHANGE YOUR MAJOR OR SCHOOL? EXPLAIN: _____

DATES AVAILABLE FOR EXTERN ASSIGNMENT: From _____ To _____, 1986

DESCRIBE CLEARLY AND SPECIFICALLY THE TYPE OF EXTERN ASSIGNMENT YOU DESIRE:

E X T E R N S H I P S I T E P R E F E R E N C E

INDICATE BY PRIORITY THE PREFERRED IHS AREA/PROGRAM LOCATION FOR EXTERNSHIP:

_____Aberdeen SD	_____Navajo, AZ	_____Bemidji, MN
_____Albuquerque, NM	_____Okla. City, OK	_____Sacramento, CA
_____Anchorage, AK	_____Phoenix, AZ	_____Tucson, AZ
_____Billings, MT	_____Portland, OR	_____Nashville, TN

INDICATE YOUR PREFERRED IHS HOSPITAL/CLINIC FOR EXTERNSHIP

(1) _____ (3) _____
(2) _____ (4) _____

COMMENTS: _____

EXTERN APPLICANT'S SIGNATURE _____ DATE _____

EXTERN COORDINATOR'S SIGNATURE _____ DATE _____

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Request for Extern Travel Reimbursement

Travel expenses are paid as follows: per diem $35 per day (automobile travel must cover a minimum of 300 miles per day), and mileage at 20.5¢ per mile, or coach air fare.

EXTERN APPLICANT'S NAME _____ HEALTH DISCIPLINE _____

GRANT NUMBER _____ NAME OF EDUCATIONAL INSTITUTION _____

THIS TRAVEL REQUEST IS BASED ON (Indicate one):

____ESTIMATED EXPENSES ____ACTUAL EXPENSES (attach all receipts)

PURPOSE OF TRAVEL: _____

DATES OF TRAVEL: _____

LOCATION OF TRAVEL: FROM _____ TO _____

NUMBER OF AUTO MILES: _____

NUMBER OF DAYS: _____

COACH AIR FARE: _____

Comments: _____

_____

_____

EXTERN APPLICANT'S SIGNATURE _____ DATE _____

EXTERN'S SUPERVISOR or BRANCH CHIEF SIGNATURE _____ DATE _____

SECTION 104

PENALTIES AND SERVICE OBLIGATIONS - SECTION 104

SECTION I

PENALTIES FOR VIOLATION OF THE INDIAN HEALTH SCHOLARSHIP PROGRAM CONTRACT FOR SECTION 104

It is your responsibility to read and understand the IHS contract. In brief, the contract provides three penalties to which the Section 104 scholarship recipient is subject:

FINE

A $1,500 fine if the Section 104 recipient, after both parties (recipient and representative of the U.S. Government) have signed the Indian Health Scholarship Program Contract, fails to accept payment or instructs the health professions school not to accept scholarship award payments or otherwise declines to accept the scholarship award.

REPAYMENT FOR ACADEMIC FAILURE OR OTHER TERMINATION

Repayment of ALL scholarship funds paid directly to the student and on his/her behalf to a health professions school if the Section 104 recipient fails to maintain the required level of academic standing in the scholarship-funded curriculum, is dismissed from the health professions school for disciplinary reasons, or voluntarily terminates the curriculum for which scholarship is awarded.

REPAYMENT FOR GRADUATE WHO REFUSES TO FULFILL SERVICE OBLIGATION

If a Section 104 recipient graduates and refuses to begin or to complete the period of service obligation, repayment is an amount equal to THREE TIMES the scholarship funds paid directly to the recipient and on his/her behalf to the educational institution, plus interest at the prevailing interest rate.

FOR SECTION 104 SCHOLARSHIP APPLICANTS ONLY

INDIAN HEALTH SCHOLARSHIP PROGRAM CONTRACT

Section 757 of the Public Health Service Act (42 U.S.C. 294y-1) authorizes the Secretary of Health and Human Services (Secretary) to award "Indian Health Scholarships" under the National Health Service Corps Scholarship Program established by section 751 of the Act. Regulations specifically applicable to the Indian Health Service Scholarship Program were published on November 18, 1977 in 42 Federal Register 59651. Applicants selected to participate in the Indian Health Scholarship Program ("Scholarship Program") will be provided a scholarship award in return for their agreement to perform a period of obligated service in (1) the Indian Health Service, (2) an urban Indian organization assisted under Title V of the Indian Health Care Improvement Act, or (3) under certain conditions in the private practice of his or her profession.

Section 751(b)(4) requires applicants to submit with their applications a signed contract stating the terms and conditions of participation in the Scholarship Program. The Secretary will sign only those contracts submitted by applicants who are selected for participation and to whom a scholarship award will be made. The terms and conditions of the contract are set out below:

Section A - Obligations of the Secretary

Subject to the availability of appropriated funds for the Indian Health Scholarship Program, the Indian Health Service, and Title V of the Indian Health Care Improvement Act, the Secretary agrees to:

1. Provide the undersigned applicant ("applicant") with a scholarship award for the school year 1985-1986 during which the applicant:
   a. is enrolled, or is accepted for enrollment, as a full-time student in an accredited (as determined by the Secretary) educational institution in one of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Island, the Virgin Islands, Guam, American Samoa or the Trust Territory of the Pacific Islands, and
   b. is pursuing a course of study leading to a degree in medicine, osteopathy, dentistry, or other health profession which has been approved by the Secretary for participation in the Scholarship Program.

   The scholarship award consists of: (1) tuition, (2) an amount for all other reasonable educational expenses incurred by the student, and (3) a monthly stipend for the 12 month period beginning with the first month of each school year in which the applicant is a participant in the Scholarship Program. The Secretary may contract with the educational instituion to pay on behalf of the applicant the amount of his tuition, and other reasonable education expenses.
2. Accept the individual into the Indian Health Service or accept equivalent service as provided in section B(4) of this contract in fulfillment of the individual's service obligation.
3. Defer the date on which the applicant must begin to service his period of obligated service for a period not to exceed three years to complete intership, residency or other advanced clinical training. Deferment will only be granted to applicants who receive degrees in medicine, osteopathy, or dentistry. Applicants who receive degrees in health professions other than medicine, osteopathy or dentistry are not eligible for deferment.

Section B - Obligations of the Applicant

The applicant agrees to:
1. Accept the scholarship award provided by the Secretary under section A(1) of this contract for the school year 1985-1986
2. Maintain full-time enrollment until completion of the course of study for which the scholarship award is provided.
3. Maintain an acceptable level of academic standing while enrolled in the course of study for which the scholarship award is provided.
4. Serve, as determined by the Director of the Indian Health Service, in the full-time clinical practice of his or her profession in:
   (a) The Indian Health Service;
   (b) an urban Indian organization assisted under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.); or
   (c) in the private practice of his or her profession if practice (1) is situated in a health manpower shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e) and (2) addresses the health care needs of a substantial number of Indians as determined by the Director, Indian Health Service, and
5. Serve one year of obligated service for each year of scholarship award is provided, or two years, whichever is greater.

Section C - Breach of Scholarship Contract

After this contract is signed by both the applicant and the Secretary, the applicant:
1. Fails to accept payment or instructs the educational institution to which scholarship payments are to be made not to accept payments under this contract, the applicant shall, in addition to the service or obligations incurred under this contract, pay to the United States the sum of $1,500 liquidated damages.

2. Fails to maintain an acceptable level of academic standing in the course of study for which the scholarship award is provided, or voluntarily terminates academic training before the completion of such training, or is dismissed from the educational institution for disciplinary or other reasons the applicant shall, instead of performing the service obligation incurred under this contract, repay to the United States all funds paid to the applicant and to the educational institution under this contract.
3. Fails to begin or complete the period of obligated service incurred under this contract for any reason, the United States shall be entitled to recover an amount equal to three times the scholarship funds awarded, plus interest as determined by the formula:

$$A = 3F\frac{(t-s)}{t}$$

in which:

---"A" is the amount the United States is entitled to recover,

---"F" is the sum of the amounts paid to or on behalf of the applicant and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the United States,

---"t" is the total number of months in the applicant's period of obligated service, and

---"s" is the number of months of such period served by the applicant in accordance with Section 757 (b)(2) of the Public Health Service Act.

The amount the United States is entitled to recover shall be paid within one year of the date the Secretary determines that the applicant has failed to begin or complete the period of obligated service.

Section D - Credibility of Graduate Training Toward the Period of Obligated Service

1. Except as provided in paragraph 2 of this section, no period of internship, residency, or other advanced clinical training will be counted toward satisfying the period of obligated service incurred under this contract.
2. Applicants who received funds under the Public Health and National Health Service Corps Scholarship Training Program (Section 225 of the Public Health Service Act as in effect September 30, 1977) for any school year beginning before October 12, 1976, will receive credit toward satisfying the period of obligated service for any period of internship or residency served in a Public Health Service or National Health Service Corps facility. Applicants who received funds for the first time under the Public Health and National Health Service Corps Scholarship Training Program as in effect September 30, 1977, for the school year 1977-78 will receive credit toward the period of obligated service for only one year of internship or residency served in a Public Health Service or National Health Service Corps facility.

Section E - Cancellation, Suspension and Waiver of Obligation

1. Any service or payment obligation incurred by the applicant under this contract will be cancelled upon the applicant's death.
2. The Secretary may waive or suspend the applicant's service or payment obligation incurred under this contract if:
   (a) compliance by the applicant with the terms and conditions of this contract is impossible or would involve extreme hardship, and
   (b) enforcement of such obligation would be unconscionable.

Section F - Contract Extension

1. The applicant may annually request extenion of this contract, for a period not to exceed 12 months, in accordance with procedures established by the Secretary.
2. Subject to the availability of funds appropriated by the Congress of the United States for the Scholarship Program, and the Indian Health Service, the Secretary shall grant request for contract extension if:
   (a) the request does not extend the total period of scholarhip award beyond four years, and
   (b) the applicant is otherwise eligible for continued participation in the Scholarship Program.

The Secretary or his authorized representative must sign this contract before it becomes effective.

Applicant Name (Please Print)	Secretary of Health and Human Services or Authorized Representative
Applicant Signature	
Date	Date

SERVICE OBLIGATION UNDER HEALTH PROFESSIONS SCHOLARSHIP SECTION 104

Subject to applicable regulations and to the Indian Health Scholarship Program Contract, there is a requirement that a Section 104 recipient serve one year for each year of scholarship support which he/she receives. Minimum period of service is two years. The IHS Headquarters Branch Chief for your academic discipline will review assignment opportunities with each graduating student early in the final school year and will work with the student to confirm an assignment. However, the ultimate responsibility for seeking a position is the scholarship recipient's.

The Director, IHS, reserves the right to make final decisions regarding assignment of scholarship recipients to fulfill their service obligation. Priority for assignment of graduates to fulfill the service obligation is currently given to placement in IHS facilities. Tribal health programs are considered to be within this IHS category.

In the event that an IHS or tribal placement cannot be arranged, you may develop an assignment in: 1) an urban Indian organization assisted under Title V of P.L. 94-437, or 2) private practice in a designated health manpower shortage area which addresses the health care needs of a substantial number of Indians.

Every effort will be made to assign you to the IHS geographic area of your preference; however, this may not be possible and you may be assigned to another IHS geographic area where there is an existing need.

APPLICATION

Graduating students may apply for employment through the Federal Civil Service or the Public Health Service Commissioned Corps. If you apply for the Civil Service, you must submit a complete application consisting of:

1. Personal Qualification Statement - Standard Form 171 - See Appendix
2. Section 104 Service Obligation Preferred Assignment
3. Verification of Indian Preference for Employment (BIA Form 5-4432) - If you do not have this, you must contact BIA directly for this form.

If your health profession is any of the following, you may wish to apply for service through the Commissioned Corps: medical, dental, nursing (BSN), pharmacy, engineering, therapy, dietitian, sanitarian or master's level health professional training. To receive information and an application form for the Corps, contact the Headquarters Branch Chief for your academic discipline or Mr. John Gimon, Acting Chief, Health Manpower Support Branch. In addition to the Commissioned Corps Application, the following should be included

1. Section 104 Service Obligation Preferred Assignment
2. Verification of Indian Preference for Employment (BIA Form 5-4432) - If you do not have this, you must contact BIA directly for this form.

When you submit your application form to the IHS, be sure to indicate clearly that you are a scholarship program graduate. This will assure that you receive priority consideration for jobs for which you qualify.

SERVICE OBLIGATION UNDER HEALTH PROFESSIONS SCHOLARSHIP SECTION 104

APPLICATION DUE DATE

Scholarship recipients who will graduate in May thru August must complete signed and dated applications which must be received before close of business on the deadline date of February 20, or must be clearly postmarked by no later than midnight February 18, and addressed as follows:

Public Law 94-437 Title I Scholarship Program
Human Resources Management Branch
Parklawn Building, Room 6A-23
5600 Fishers Lane
Rockville, Maryland 20857
ATTENTION: Service Obligation Coordinator

The Commissioned Corps Application should be sent to:

Commissioned Personnel Operations Division
Office of Personnel Management/OM/PHS
Room 4-35, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

SERVICE OBLIGATION UNDER HEALTH PROFESSIONS SCHOLARSHIP SECTION 104

SERVICE OBLIGATION DEFERMENT

Section 104 scholarship recipients must begin their obligated service within 60 days after graduation or on the date of their appointment unless the obligation has been deferred. If deferment occurs obligated service must begin within 60 days after the end of the deferred time period. A prior approval request for deferment must be submitted in writing, to the following address, as soon as you become aware of the need for a deferment:

Public Law 94-437 Title I Scholarship Program
Human Resources Management Branch
Parklawn Building, Room 6A-23
5600 Fishers Lane
Rockville, Maryland 20857
ATTENTION: Service Obligation Coordinator

OMB APPROVED: No. 0915-0080 I-07

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Section 104 Service Obligation Preferred Assignment

NAME _____ GRANT NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

AREA CODE AND TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

B A C K G R O U N D

HEALTH PROFESSIONS DISCIPLINE: _____

GRADUATION DATE: _____

TYPE OF DEGREE CONFERRED: _____

NAME OF UNIVERSITY: _____

DESCRIBE CLEARLY AND SPECIFICALLY THE TYPE OF WORK ASSIGNMENT YOU DESIRE TO COMPLETE YOUR SERVICE OBLIGATION: _____

_____

_____

MY SERVICE OBLIGATION PERIOD CONSISTS OF (circle one): 2 3 4 years.

S E R V I C E O B L I G A T I O N P R E F E R E N C E

INDICATE BY PRIORITY (1 - first, 2 - second, etc.) YOUR CHOICE OF LOCATIONS TO COMPLETE YOUR SERVICE OBLIGATION:

_____Indian Health Service _____Urban Indian Health Program
_____Tribal Health Program _____Private Practice _____Other - Explain: _____

IF YOU CHOOSE THE IHS INDICATE BY PRIORITY THE PREFERRED IHS AREA/PROGRAM OFFICE LOCATION:

_____Aberdeen SD	_____Navajo, AZ	_____Bemidji, MN
_____Albuquerque, NM	_____Okla. City, OK	_____Sacramento, CA
_____Anchorage, AK	_____Phoenix, AZ	_____Tucson, AZ
_____Billings, MT	_____Portland, OR	_____Nashville, TN

IDENTIFY NON-IHS LOCATIONS: _____

_____

I understand that IHS officials negotiate the assignment; however, the Director, IHS has the right to make the final decision regarding my Health Professions Section 104 Service Obligation assignment.

APPLICANT'S SIGNATURE _____ DATE _____

SECTION 104 SERVICE OBLIGATION REPORT REQUIREMENTS

Within 60 days of the beginning of your service obligation employment you must submit documents to verify your employment and submit a copy of your position description. If the documents are not received within 60 days after the beginning of your employment your account is forwarded to the Public Health Service Claims Officer for collection. Additionally you must submit an annual status report. All documents and status reports should be mailed to the following address:

Public Law 94-437 Title I Scholarship Office
Human Resources Management Branch
Parklawn Building, Room 6A-23
5600 Fishers Lane
Rockville, MD 20857
ATTENTION: Service Obligation Coordinator

OMB APPROVED: No. 0915-0080

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Section 104 Service Obligation Annual Status Report

NAME _____ GRANT NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

WORK AREA CODE AND TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

HEALTH PROFESSIONS DISCIPLINE: _____

GRADUATION DATE: _____

TYPE OF DEGREE CONFERRED: _____

NAME OF UNIVERSITY: _____

ASSIGNMENT LOCATION: _____Indian Health Service ___Urban Indian Health Program
_____Tribal Health Program ___Private Practice ____Other

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

MY CURRENT POSITION TITLE: _____
(Attach to this report a copy of your current position description.)

Non-IHS employees must attach a summary which identifies the purpose, mission or nature of the employing organization and the population served by the organization.

COMMENTS: _____

Scholarship Recipient's Signature _____ Date _____

Immediate Supervisor's Signature _____ Date _____

Supervisor's Title _____ Supervisor's Telephone Number _____

OMB APPROVED: No. 0915-0080

I-09

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Section 104 Service Obligation Annual Status Report

NAME _____ GRANT NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

WORK AREA CODE AND TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

HEALTH PROFESSIONS DISCIPLINE: _____

GRADUATION DATE: _____

TYPE OF DEGREE CONFERRED: _____

NAME OF UNIVERSITY: _____

ASSIGNMENT LOCATION: _____Indian Health Service ___Urban Indian Health Program
_____Tribal Health Program ___Private Practice ____Other

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

MY CURRENT POSITION TITLE: _____
(Attach to this report a copy of your current position description.)

Non-IHS employees must attach a summary which identifies the purpose, mission or nature of the employing organization and the population served by the organization.

COMMENTS: _____

Scholarship Recipient's Signature _____ Date _____

Immediate Supervisor's Signature _____ Date _____

Supervisor's Title _____ Supervisor's Telephone Number _____

OMB APPROVED: No. 0915-0080

I-09

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

Section 104 Service Obligation Annual Status Report

NAME _____ GRANT NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

WORK AREA CODE AND TELEPHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

HEALTH PROFESSIONS DISCIPLINE: _____

GRADUATION DATE: _____

TYPE OF DEGREE CONFERRED: _____

NAME OF UNIVERSITY: _____

ASSIGNMENT LOCATION: _____Indian Health Service ___Urban Indian Health Program
_____Tribal Health Program ___Private Practice ____Other

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

MY CURRENT POSITION TITLE: _____
(Attach to this report a copy of your current position description.)

Non-IHS employees must attach a summary which identifies the purpose, mission or nature of the employing organization and the population served by the organization.

COMMENTS: _____

Scholarship Recipient's Signature _____ Date _____

Immediate Supervisor's Signature _____ Date _____

Supervisor's Title _____ Supervisor's Telephone Number _____

OMB APPROVED: No. 0915-0080

I-09

INDIAN HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC LAW 94-437 TITLE I SCHOLARSHIP PROGRAM

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Supervisor's Title _____ Supervisor's Telephone Number _____

CONTINUATION SUPPORT

SECTION J

CONTINUATION SUPPORT

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM - Section 103

Section 103 - Limitation of Support

The Section 103 program makes scholarship support available for up to two academic years (August through May) of compensatory or preprofessional education, which, upon completion, enables the student to qualify for enrollment or reenrollment in a health professions school. Only those students who meet the continued eligibility requirements and have been recommended for continuation will be given priority consideration for additional periods of scholarship support.

Section 103 - Continued Eligibility

Recipients of Section 103 funding must apply annually for continuation beyond the initial funding period and must meet specific eligibility criteria for consideration. The criteria are: 1) recipient must maintain an overall 2.0 grade point average in the health/allied health preprofessions curriculum and 2) must be enrolled for the next semester/quarter in 12 credit hours or whatever number of credit hours which the school considers full-time.

HEALTH PROFESSIONS PREGRADUATE SCHOLARSHIP PROGRAM - SECTION 103P

Section 103P - Limitation of Support

This program makes scholarship support available for up to four academic years (August through May) of pregraduate education, which, upon completion, enables the student to qualify for enrollment in a medical school. Only those students who meet the continued eligibility requirement and have been reviewed and recommended for continuation will be given priority consideration for additional periods of support.

Section 103P - Continued Eligibility

Recipients of Section 103P funding must apply annually for continuation beyond the initial funding period and must meet specific eligibility criteria for consideration. The criteria are: 1) recipient must maintain an overall 2.5 grade point average in the premedical program, and 2) must be enrolled for the next semester/quarter in 12 credit hours or whatever number of credit hours the school considers full-time.

HEALTH PROFESSIONS SCHOLARSHIP PROGRAM - SECTION 104

Section 104 - Limitation of Support

Scholarship support for Section 104 recipients is available for up to four calendar years of health professional education. Each scholarship grant is awarded for a one year period with reapplication for each continuation year.

CONTINUATION SUPPORT

Those students who meet specific continued eligibility requirements and have been reviewed and recommended for continuation will be given priority consideration for additional periods of support.

Section 104 - Continued Eligibility

A recipient of a Section 104 scholarship must continue to meet the following eligibility requirements: 1) maintain an overall 2.0 grade point average in the chosen health/allied health professions curriculum, and 2) be enrolled in 12 credit hours for the next semester/quarter or the number of credit hours considered full-time by the health professions program.

APPENDIX

Standard Form 171

Personal Qualifications Statement

IMPORTANT

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR STATEMENT

- You must furnish all requested information. The information you provide will be used to determine your qualifications for employment. DO NOT SEND A RESUME IN LIEU OF COMPLETING THIS STATEMENT.
- If you fail to answer all questions on your Statement fully and accurately, you may delay consideration of your Statement and may lose employment opportunities. See the Privacy Act Information on the reverse of this sheet.
- So that it is understood that you did not omit an item, please write the letters "N/A" (Not Applicable) beside those items that do not apply to you, unless instructions indicate otherwise.

GENERAL INSTRUCTIONS

- If you are applying for a specific Federal civil service examination:
  - —Read the examination announcement or the Qualifications Information Statement for the position to be certain that your experience and education are qualifying.
  - —If a written test is required, follow the filing instructions on the admission card.
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  - —Please typewrite or write legibly or print clearly in dark ink.

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- Enter the lowest grade or the lowest salary you will accept. You will not be considered for any lower grades or salary. You will be considered for any higher grades or salaries for which you qualify as specified in the examination announcement or the Qualifications Information Statement.

ITEM 16. Other Government and International Agencies

- The Office of Personnel Management is occasionally requested to refer for employment consideration the names of eligibles on competitive registers to State and local government agencies, congressional and other public offices, and public international organizations. Indicate your availability by checking the appropriate boxes. Your response to this question will not affect your consideration for other positions.

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- Indicate the number of nights per month you are willing to be away from home in a travel status. Some jobs require nearly constant travel of two or three weeks every month while others require infrequent, short or occasional extended periods of travel. You will be considered for positions requiring travel based on the number of nights per month for which you indicate travel availability.

ITEM 20. Active Military Service and Veteran Preference

- Five-point veteran preference is granted to veterans who receive an honorable or general discharge from the armed forces:
  - (a) after active duty during the periods April 6, 1917 to July 2, 1921 and December 7, 1941 to July 1, 1955;
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    NOTE—Service under an initial period of active duty for training under the "6-month" Reserve or National Guard programs is not creditable for veteran preference; and
  - (c) after service in a campaign for which a campaign badge has been authorized.
- Non-disabled veterans who retired at or above the rank of major or its equivalent are not eligible for veteran preference after October 1, 1980.
- You will be required to furnish records to support your claim for five-point preference only at the time of your appointment.
- Ten-point veteran preference is granted to:
  (a) disabled veterans; and
  (b) veterans awarded the Purple Heart.
  Ten-point veteran preference is granted in certain cases to:
  (a) unmarried widows and widowers of veterans;
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  (c) mothers of deceased or disabled veterans.
  If you claim ten-point veteran preference, submit Standard Form 15, Claim for 10-Point Veteran Preference, and the required proof with this application. Obtain SF 15 and information on provisions of the Veteran Preference laws at any Federal Job Information Center.
- A clemency discharge does not meet the Veteran Preference Act requirement for discharge under honorable conditions. Accordingly, no preference may be granted to applicants with such discharge.

ITEM 21. Experience

- Fill in these experience blocks carefully and completely. A large part of your qualifications rating depends upon a thorough description of your experience and employment history.
- If you fail to give complete details, you may delay consideration of your Statement. Your description of duties may be verified with former employers.
- If you supervise or have supervised other employees, be sure to indicate the number and kind (and grades, if Federal Government) of employees supervised, and describe your duties as a supervisor under Description of Work.
- Volunteer Experience—You may receive credit for pertinent religious, civic, welfare service and organizational work performed with or without compensation. Show the actual amount of time spent in such work (for example, average hours per week or month). Complete all the items just as you would for a compensable position.
- Use separate blocks if your duties, responsibilities, or salary have changed materially while working for the same employer. Treat each such change as a separate position.

PLEASE READ ADDITIONAL INSTRUCTIONS ON BACK OF THIS SHEET

ITEM 21. Experience *(Continued)*

NOTE—Experience gained more than 15 years ago may be summarized in one block if it is not pertinent to the type of position you applied for.

- Include your military or merchant marine service in separate blocks in order and describe major duty assignments.
- Indicate in each block of Item 21 the name under which you were employed if it was different from the name in Item 6 of this Statement. Show former name in parentheses after "Description of duties and accomplishments in your work."
- Indicate any period of unemployment exceeding three months and your address at that time on the last line of the preceding experience block.
- Block A—Describe your present position in this block. Indicate if you are now unemployed or if you have never been employed.
- Blocks B and C—Describe in Block B the position you held just before your present position and continue to work backwards using Block C.
- Enter the average number of hours per week you work. If you work part time, indicate the average number of hours per week you work.
- Description of Work—Describe each job briefly, including required skills and abilities. Describe any specialties and special assignments, your authority and responsibility, your relationships to others, your accomplishments, and any other factors which help to describe the job.
- If your job contains experience in more than one type of work (for example: carpentry and painting, or personnel and budget) estimate and indicate the approximate percentage of time spent in each type of work. Place the percentages in parentheses at the end of the description of work.
- If you need additional experience blocks:
  —Use Standard Form 171-A, Continuation Sheet; or
  —A plain sheet of paper approximately 8 by 10½ inches in size. Be sure to include all of the information requested in Item 21.

  If you need additional space to describe a position held:
  —Continue in Item 34, Space for Detailed Answers; or
  —Continue on a plain sheet of paper.
- Identify each plain sheet of paper used by showing your name, birth date, examination or position title, and the block under Item 21 from which the description is continued.
- Attach all supplemental sheets to the top of page 3.

ITEM 32. Relatives Employed by the United States Government

- A Federal official (civilian or military) may not appoint any of his or her relatives or recommend them for employment in his or her agency, and a relative who is appointed in violation of this restriction cannot be paid. Therefore it is necessary to have information about your relatives who are working for the Federal Government. In listing relative(s) in answer to question 32 include: father; mother; son; daughter; brother; sister; uncle; aunt; first cousin; nephew; niece; husband; wife; father-in-law; mother-in-law; son-in-law; daughter-in-law; brother-in-law; sister-in-law; stepfather; stepmother; stepson; stepdaughter; stepbrother; stepsister; half brother, and half sister.

CERTIFICATION

- Be careful that you have answered all questions on your Statement correctly and considered all statements fully so that your eligibility can be decided on all the facts. Read the certification carefully before you sign and date your Statement.
- Sign your name in ink.
- Use one given name, initial or initials, and last name.

PRIVACY ACT INFORMATION

The Office of Personnel Management is authorized to rate applicants for Federal jobs under Sections 1302, 3301, and 3304 of Title 5 of the U.S. Code. We need the information you put on this form to see how well your education and work skills qualify you for a Federal job. We also need information on matters such as citizenship and military service to see whether you are affected by laws we must follow in deciding who may be employed by the Federal Government. We cannot give you a rating, which is the first step toward getting a job, if you do not answer these questions.

We must have your Social Security Number (SSN) to keep your records straight because other people may have the same name and birthdate. The SSN has been used to keep records since 1943, when Executive Order 9397 asked agencies to do so. The Office of Personnel Management may also use your SSN to make requests for information about you from employers, schools, banks, and others who know you, but only as allowed by law. The information we collect by using your SSN will be used for employment purposes and also for studies and statistics that will not identify you.

Information we have about you may also be given to Federal, State, and local agencies for checking on law violations or for other lawful purposes. We may also notify your school placement office if you are selected for a Federal job.

PLEASE DETACH THIS INSTRUCTION SHEET BEFORE SUBMITTING YOUR STATEMENT

Personal Qualifications Statement

Read instructions before completing form

Form Approved:
OMB No. 3206-0012

1. Kind of position *(job)* you are filing for *(or title and number of announcement)*

2. Options for which you wish to be considered *(if listed in the announcement)*

3. Home phone — Area Code | Number

4. Work phone — Area Code | Number | Extension

5. Sex *(for statistics only)* — ☐ Male ☐ Female

6. Other last names ever used

Name *(Last, First, Middle)*

Street address or RFD no. *(include apartment no., if any)*

City | State | ZIP Code

8. Birthplace *(City & State, or foreign country)*

9. Birth date *(Month, day, year)*

10. Social Security Number

11. If you have ever been employed by the Federal Government as a civilian, give your highest grade, classification series, and job title.

Dates of service in highest grade *(Month, day, and year)*

From To

12. If you currently have an application on file with the Office of Personnel Management for appointment to a Federal position, list: (a) the name of the area office maintaining your application, (b) the position for which you filed, and *(if appropriate)* (c) the date of your notice of rating, (d) your identification number, and (e) your rating.

13. Lowest pay or grade you will accept

PAY: $ per — OR — GRADE

14. When will you be available for work? *(Month, and year)*

DO NOT WRITE IN THIS BLOCK
FOR USE OF EXAMINING OFFICE ONLY

Material: ☐ Submitted ☐ Returned

Entered register:

Notations:

Form reviewed:

Form approved:

ANNOUNCEMENT NO.

STATEMENT NO.

Option	Grade	Earned Rating	Preference	Aug Rating
			☐ 5 Points (Tent.)	
			☐ 10 Pts. 30% or More Comp. Dis.	
			☐ 10 Pts. Less Than 30% Comp. Dis.	
			☐ Other 10 Points	
			☐ Disallowed	
Initials and date			☐ Being Investigated	

THIS SPACE FOR USE OF APPOINTING OFFICER ONLY

Preference has been verified through proof that the separation was under honorable conditions, and other proof as required.

☐ 5-Point ☐ 10 Points 30% or More Compensable Disability ☐ 10 Points Less Than 30% Compensable Disability ☐ 10-Point Other

Signature and title

Agency | Date

15. Are you available for temporary employment lasting:

(Acceptance or refusal of temporary employment will not affect your consideration for other appointments.)

	YES	NO
A. Less than 1 month?		
B. 1 to 4 months?		
C. 5 to 12 months?		

16. Are you interested in being considered for employment by

	YES	NO
A. State and local government agencies?		
B. Congressional and other public offices?		
C. Public international organizations?		

17. Where will you accept a job?

	YES	NO
A. In the Washington, D.C. Metropolitan area?		
B. Outside the 50 United States?		
C. Anyplace in the United States?		
D. Only in *(specify locality)*		

18. Indicate your availability for overnight travel.

A. Not available for overnight travel	
B. 1 to 5 nights per month	
C. 6 to 10 nights per month	
D. 11 or more nights per month	

19. Are you available for part-time positions *(fewer than 40 hours per week)* offering

	YES	NO
A. 20 or fewer hours per week?		
B. 21 to 31 hours per week?		
C. 32 to 39 hours per week?		

20. Veteran Preference. Answer all parts. If a part does not apply to you, answer "NO"

	YES	NO
A. Have you ever served on active duty in the United States military service? *(Exclude tours of active duty for training in Reserves or National Guard)*		
B. Have you ever been discharged from the armed services under other than honorable conditions? *You may omit any such discharge changed to honorable or general by a Discharge Review Board or similar authority)* If "YES", give details in item 34		
C. Do you claim 5-point preference based on active duty in the armed forces? If "YES", you will be required to furnish records to support your claim at the time you are appointed.		
D. Do you claim 10-point preference? If "YES," check the type of preference claimed and complete and attach Standard Form 15, "Claim for 10-Point Veteran Preference," together with the proof requested in that form.		

Type of Preference: ☐ Compensable Disability 30% or More ☐ Compensable Disability Below 30% ☐ Non-compensable Disability ☐ Purple Heart Recipient ☐ Spouse ☐ Widow(er) ☐ Mother

E. List dates, branch, and serial number of all active service *(enter "N/A", if not applicable)*

From To Branch of Service Serial or Service Number

21 Experience. Begin with current or most recent job or volunteer experience and work back. Account for periods of unemployment exceeding three months and your residence address at that time on the last line of the experience blocks in order of occurrence.

May inquiry be made of your present employer regarding your character, qualifications, and record of employment? ☐ YES ☐ NO
(A "NO" will not affect your consideration for employment opportunities except for Administrative Law Judge positions.)

A Name and address of employer's organization *(include ZIP code, if known)*

Dates employed *(give month and year)*
From To

Average number of hours per week

Salary or earnings
Beginning $ per
Ending $ per

Place of employment
City
State

Exact title of your position	Name of immediate supervisor. Area Code. Telephone number	Number and kind of employees you supervise
Kind of business or organization *(manufacturing, accounting, social services, etc.)*	If Federal service, civilian or military, series, grade or rank, and date of last promotion	Your reason for wanting to leave

Description of work *(Describe your specific duties, responsibilities, and accomplishments in this job)*

For agency use *(skill codes, etc.)*

B Name and address of employer's organization *(include ZIP code, if known)*

Dates employed *(give month and year)*
From To

Average number of hours per week

Salary or earnings
Beginning $ per
Ending $ per

Place of employment
City
State

Exact title of your position	Name of immediate supervisor. Area Code. Telephone number	Number and kind of employees you supervised
Kind of business or organization *(manufacturing, accounting, social services, etc.)*	If Federal service, civilian or military, series, grade or rank, and date of last promotion	Your reason for leaving

Description of work *(Describe your specific duties, responsibilities, and accomplishments in this job)*

For agency use *(skill codes, etc.)*

C Name and address of employer's organization *(include ZIP code, if known)*

Dates employed *(give month and year)*
From To

Average number of hours per week

Salary or earnings
Beginning $ per
Ending $ per

Place of employment
City
State

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Description of work *(Describe your specific duties, responsibilities, and accomplishments in this job)*

For agency use *(skill codes, etc.)*

If you need additional experience blocks, use Standard Form 171-A or blank sheets of paper

SEE INSTRUCTION SHEET

Attach Supplemental Sheets or Forms Here

22 A Special qualifications and skills *(skills with machines, patents or inventions, your most important publications [do not submit copies unless requested], your public speaking and publications experience, membership in professional or scientific societies, etc.)*

B Kind of license or certificate *(pilot, registered nurse, lawyer, radio operator, CPA, etc.)*

C Latest license or certificate — Year | State or other licensing authority

D Approximate number of words per minute — Typing | Shorthand

23 A Did you graduate from high school or will you graduate within the next nine months, or do you have a GED high school equivalency certificate?

Yes | Month and Year | No | Highest grade completed

B Name and location *(city and State)* of latest high school attended

C Name and location *(city, State, and ZIP Code, if known)* of college or university *(If you expect to graduate within nine months, give MONTH and YEAR you expect to receive your degree.)*	Dates Attended		Years Completed		No. of Credits Completed		Type of Degree *(e.g., B.A.)*	Year of Degree
	From	To	Day	Night	Semester Hours	Quarter Hours		

D Chief undergraduate college subjects	No. of Credits Completed		E Chief graduate college subjects	No. of Credits Completed	
	Semester Hours	Quarter Hours		Semester Hours	Quarter Hours

F Major field of study at highest level of college work

G Other schools or training *(for example, trade, vocational, Armed Forces or business)*. Give for each the name and location *(city, State and ZIP Code, if known)* of school, dates attended, subjects studied, number of classroom hours of instruction per week, certificate, and any other pertinent data.

24 Honors, awards, and fellowships received

25 Languages other than English. List the languages *(other than English)* in which you are proficient and indicate your level of proficiency by putting a check mark (✓) in the appropriate columns. **Candidates for positions requiring conversational ability in a language other than English may be given an interview conducted solely in that language.** Describe in item 34 how you gained your language skills and the amount of experience you have had *(e.g., completed 72 hours of classroom training, spoke language at home for 18 years, self-taught, etc.)*.

Name of Language(s)	PROFICIENCY							
	Can Prepare and Deliver Lectures		Can Converse		Have Facility to Translate Articles, Technical Materials, etc.		Can Read Articles, Technical Materials, etc. for Own Use	
	Fluently	With Difficulty	Fluently	Passably	Into English	From English	Easily	With Difficulty

26 References. List three persons who are NOT related to you and who have definite knowledge of your qualifications and fitness for the position for which you are applying. Do not repeat names of supervisors listed under Item 21, Experience.

Full Name	Present Business or Home Address *(Number, Street, City, State and ZIP Code)*	Telephone Number *(Include Area Code)*	Business or Occupation

Answer items 27 through 33 by placing an "X" in the proper column	YES	NO	
27 Are you a citizen of the United States? If "NO," give country of which you are a citizen			◀
NOTE: A conviction or a firing does not necessarily mean you cannot be appointed. The circumstances of the occurrence(s) and how long ago it (they) occurred are important. Give all the facts so that a decision can be made.			◀
28 Within the last five years have you been fired from any job for any reason?			◀
29 Within the last five years have you quit a job after being notified that you would be fired? If your answer to 28 or 29 above is "YES," give details in Item 34. Show the name and address (*including ZIP Code*) of employer, approximate date, and reasons in each case. This information should agree with your answers in Item 21, Experience.			
30 A Have you **ever** been convicted, forfeited collateral, or are you now under charges for **any felony** or **any** firearms or explosives offense against the law? (*A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified under the laws of a State as a misdemeanor which is punishable by a term of imprisonment of two years or less.*)			◀
B During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in A above?			◀
NOTE: When answering A and B above, you may omit: (1) traffic fines for which you paid a fine of $50.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.			◀
31 While in the military service were you ever convicted by a general court-martial? If your answer to 30A, 30B, or 31 is "YES," give details in Item 34. Show for each offense: (1) date; (2) charge; (3) place; (4) court; and (5) action taken.			
32 Does the United States Government employ in a civilian capacity or as a member of the Armed Forces any relative of yours (*by blood or marriage*)? (*See Item 32 in the attached instruction sheet.*) If your answer to 32 is "YES," give in Item 34 for such relatives: (1) name; (2) present address (*including ZIP Code*); (3) relationship; (4) department, agency, or branch of the armed forces.			◀
33 Do you receive, or do you have pending application for, retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia Government service? If your answer to 33 is "YES," give details in Item 34. If military retired pay, include the rank at which you retired.			◀

Your Statement cannot be processed until you have answered all questions, including Items 27 through 33 above. Be sure you have placed an "X" to the left of EVERY marker (◀) above, either in the "YES" or "NO" column.

34 Item No.	Space for detailed answers. Indicate item numbers to which the answers apply.

If more space is required, use full sheets of paper approximately the same size as this page. Write on each sheet your name, birth date, and announcement or position title. Attach all sheets to this Statement at the top of page 3.

ATTENTION—THIS STATEMENT MUST BE SIGNED

Read the following paragraphs carefully before signing this Statement

A false answer to any question in this Statement may be grounds for not employing you, or for dismissing you after you begin work, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001). All the information you give will be considered in reviewing your Statement.

AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose.

CERTIFICATION	SIGNATURE (*sign in ink*)	DATE
I certify that all of the statements made by me are true, complete and correct to the best of my knowledge and belief, and are made in good faith.		

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  If you claim ten-point veteran preference, submit Standard Form 15, Claim for 10-Point Veteran Preference, and the required proof with this application. Obtain SF 15 and information on provisions of the Veteran Preference laws at any Federal Job Information Center.
- A clemency discharge does not meet the Veteran Preference Act requirement for discharge under honorable conditions. Accordingly, no preference may be granted to applicants with such discharge.

ITEM 21. Experience

- Fill in these experience blocks carefully and completely. A large part of your qualifications rating depends upon a thorough description of your experience and employment history.
- If you fail to give complete details, you may delay consideration of your Statement. Your description of duties may be verified with former employers.
- If you supervise or have supervised other employees, be sure to indicate the number and kind (and grades, if Federal Government) of employees supervised, and describe your duties as a supervisor under Description of Work.
- Volunteer Experience—You may receive credit for pertinent religious, civic, welfare service and organizational work performed with or without compensation. Show the actual amount of time spent in such work (for example, average hours per week or month). Complete all the items just as you would for a compensable position.
- Use separate blocks if your duties, responsibilities, or salary have changed materially while working for the same employer. Treat each such change as a separate position.

PLEASE READ ADDITIONAL INSTRUCTIONS ON BACK OF THIS SHEET

ITEM 21. Experience *(Continued)*

NOTE—Experience gained more than 15 years ago may be summarized in one block if it is not pertinent to the type of position you applied for.

- Include your military or merchant marine service in separate blocks in order and describe major duty assignments.
- Indicate in each block of Item 21 the name under which you were employed if it was different from the name in Item 6 of this Statement. Show former name in parentheses after "Description of duties and accomplishments in your work."
- Indicate any period of unemployment exceeding three months and your address at that time on the last line of the preceding experience block.
- Block A—Describe your present position in this block. Indicate if you are now unemployed or if you have never been employed.
- Blocks B and C—Describe in Block B the position you held just before your present position and continue to work backwards using Block C.
- Enter the average number of hours per week you work. If you work part time, indicate the average number of hours per week you work.
- Description of Work—Describe each job briefly, including required skills and abilities. Describe any specialties and special assignments, your authority and responsibility, your relationships to others, your accomplishments, and any other factors which help to describe the job.
- If your job contains experience in more than one type of work (for example: carpentry and painting, or personnel and budget) estimate and indicate the approximate percentage of time spent in each type of work. Place the percentages in parentheses at the end of the description of work.
- If you need additional experience blocks:
  —Use Standard Form 171-A, Continuation Sheet; or
  —A plain sheet of paper approximately 8 by 10½ inches in size. Be sure to include all of the information requested in Item 21.

  If you need additional space to describe a position held:
  —Continue in Item 34, Space for Detailed Answers; or
  —Continue on a plain sheet of paper.
- Identify each plain sheet of paper used by showing your name, birth date, examination or position title, and the block under Item 21 from which the description is continued.
- Attach all supplemental sheets to the top of page 3.

ITEM 32. Relatives Employed by the United States Government

- A Federal official (civilian or military) may not appoint any of his or her relatives or recommend them for employment in his or her agency, and a relative who is appointed in violation of this restriction cannot be paid. Therefore it is necessary to have information about your relatives who are working for the Federal Government. In listing relative(s) in answer to question 32 include: father; mother; son; daughter; brother; sister; uncle; aunt; first cousin; nephew; niece; husband; wife; father-in-law; mother-in-law; son-in-law; daughter-in-law; brother-in-law; sister-in-law; stepfather; stepmother; stepson; stepdaughter; stepbrother; stepsister; half brother, and half sister.

CERTIFICATION

- Be careful that you have answered all questions on your Statement correctly and considered all statements fully so that your eligibility can be decided on all the facts. Read the certification carefully before you sign and date your Statement.
- Sign your name in ink.
- Use one given name, initial or initials, and last name.

PRIVACY ACT INFORMATION

The Office of Personnel Management is authorized to rate applicants for Federal jobs under Sections 1302, 3301, and 3304 of Title 5 of the U.S. Code. We need the information you put on this form to see how well your education and work skills qualify you for a Federal job. We also need information on matters such as citizenship and military service to see whether you are affected by laws we must follow in deciding who may be employed by the Federal Government. We cannot give you a rating, which is the first step toward getting a job, if you do not answer these questions.

We must have your Social Security Number (SSN) to keep your records straight because other people may have the same name and birthdate. The SSN has been used to keep records since 1943, when Executive Order 9397 asked agencies to do so. The Office of Personnel Management may also use your SSN to make requests for information about you from employers, schools, banks, and others who know you, but only as allowed by law. The information we collect by using your SSN will be used for employment purposes and also for studies and statistics that will not identify you.

Information we have about you may also be given to Federal, State, and local agencies for checking on law violations or for other lawful purposes. We may also notify your school placement office if you are selected for a Federal job.

PLEASE DETACH THIS INSTRUCTION SHEET BEFORE SUBMITTING YOUR STATEMENT

Personal Qualifications Statement

Read instructions before completing form

Form Approved:
OMB No. 3206-0012

1. Kind of position *(job)* you are filing for *(or title and number of announcement)*

2. Options for which you wish to be considered *(if listed in the announcement)*

3. Home phone — Area Code | Number

4. Work phone — Area Code | Number | Extension

5. Sex *(for statistics only)* ☐ Male ☐ Female

6. Other last names ever used

Name *(Last, First, Middle)*

Street address or RFD no. *(include apartment no., if any)*

City | State | ZIP Code

8. Birthplace *(City & State, or foreign country)*

9. Birth date *(Month, day, year)*

10. Social Security Number

11. If you have ever been employed by the Federal Government as a civilian, give your highest grade, classification series, and job title

Dates of service in highest grade *(Month, day, and year)*

From To

12. If you currently have an application on file with the Office of Personnel Management for appointment to a Federal position, list (a) the name of the area office maintaining your application, (b) the position for which you filed, and *(if appropriate)* (c) the date of your notice of rating, (d) your identification number, and (e) your rating.

13. Lowest pay or grade you will accept

PAY: $ per — OR — GRADE

14. When will you be available for work? *(Month and year)*

DO NOT WRITE IN THIS BLOCK
FOR USE OF EXAMINING OFFICE ONLY

Material: ☐ Submitted ☐ Returned

Entered register:

Notations:

Form reviewed:

Form approved:

Option	Grade	Earned Rating	Preference	Aug. Rating
			☐ 5 Points (Tent.)	
			☐ 10 Pts. 30% or More Comp. Dis.	
			☐ 10 Pts. Less Than 30% Comp. Dis.	
			☐ Other 10 Points	
			☐ Disallowed	
Initials and date			☐ Being Investigated	

ANNOUNCEMENT NO.

STATEMENT NO.

THIS SPACE FOR USE OF APPOINTING OFFICER ONLY

Preference has been verified through proof that the separation was under honorable conditions, and other proof as required.

☐ 5-Point ☐ 10 Points 30% or More Compensable Disability ☐ 10 Points Less Than 30% Compensable Disability ☐ 10-Point Other

Signature and title

Agency | Date

15. Are you available for temporary employment lasting *(Acceptance or refusal of temporary employment will not affect your consideration for other appointments.)*

	YES	NO
A. Less than 1 month?		
B. 1 to 4 months?		
C. 5 to 12 months?		

16. Are you interested in being considered for employment by

	YES	NO
A. State and local government agencies?		
B. Congressional and other public offices?		
C. Public international organizations?		

17. Where will you accept a job?

	YES	NO
A. In the Washington, D.C. Metropolitan area?		
B. Outside the 50 United States?		
C. Anyplace in the United States?		
D. Only in *(specify locality)*		

18. Indicate your availability for overnight travel

- A. Not available for overnight travel ☐
- B. 1 to 5 nights per month ☐
- C. 6 to 10 nights per month ☐
- D. 11 or more nights per month ☐

19. Are you available for part-time positions *(fewer than 40 hours per week)* offering

	YES	NO
A. 20 or fewer hours per week?		
B. 21 to 31 hours per week?		
C. 32 to 39 hours per week?		

20. Veteran Preference. Answer all parts. If a part does not apply to you, answer "NO".

	YES	NO
A. Have you ever served on active duty in the United States military service? *(Exclude tours of active duty for training in Reserves or National Guard.)*		
B. Have you ever been discharged from the armed services under other than honorable conditions? *You may omit any such discharge changed to honorable or general by a Discharge Review Board or similar authority.* If "YES", give details in item 34.		
C. Do you claim 5-point preference based on active duty in the armed forces? If "YES", you will be required to furnish records to support your claim at the time you are appointed.		
D. Do you claim 10-point preference? If "YES," check the type of preference claimed and complete and attach Standard Form 15, "Claim for 10-Point Veteran Preference," together with the proof requested in that form.		

Type of Preference: ☐ Compensable Disability 30% or More ☐ Compensable Disability: Below 30% ☐ Non-compensable Disability ☐ Purple Heart Recipient ☐ Spouse ☐ Widow(er) ☐ Mother

E. List dates, branch, and serial number of all active service *(enter "N/A", if not applicable)*

From To Branch of Service Serial or Service Number

21. Experience. Begin with current or most recent job or volunteer experience and work back. Account for periods of unemployment exceeding three months and your residence address at that time on the last line of the experience blocks in order of occurrence.

May inquiry be made of your present employer regarding your character, qualifications, and record of employment? (A "NO" will not affect your consideration for employment opportunities except for Administrative Law Judge positions.) ☐ YES ☐ NO

A Name and address of employer's organization (include ZIP code, if known)

Dates employed (give month and year)
From To

Average number of hours per week

Salary or earnings
Beginning $ per
Ending $ per

Place of employment
City
State

Exact title of your position	Name of immediate supervisor	Area Code / Telephone number	Number and kind of employees you supervise

Kind of business or organization (manufacturing, accounting, social services, etc.)	If Federal service, civilian or military, series, grade or rank, and date of last promotion	Your reason for wanting to leave

Description of work (Describe your specific duties, responsibilities, and accomplishments in this job)

For agency use (skill codes, etc.)

B Name and address of employer's organization (include ZIP code, if known)

Dates employed (give month and year)
From To

Average number of hours per week

Salary or earnings
Beginning $ per
Ending $ per

Place of employment
City
State

Exact title of your position	Name of immediate supervisor	Area Code / Telephone number	Number and kind of employees you supervised

Kind of business or organization (manufacturing, accounting, social services, etc.)	If Federal service, civilian or military, series, grade or rank, and date of last promotion	Your reason for leaving

Description of work (Describe your specific duties, responsibilities, and accomplishments in this job)

For agency use (skill codes, etc.)

C Name and address of employer's organization (include ZIP code, if known)

Dates employed (give month and year)
From To

Average number of hours per week

Salary or earnings
Beginning $ per
Ending $ per

Place of employment
City
State

Exact title of your position	Name of immediate supervisor	Area Code / Telephone number	Number and kind of employees you supervised

Kind of business or organization (manufacturing, accounting, social services, etc.)	If Federal service, civilian or military, series, grade or rank, and date of last promotion	Your reason for leaving

Description of work (Describe your specific duties, responsibilities, and accomplishments in this job)

For agency use (skill codes, etc.)

If you need additional experience blocks, use Standard Form 171-A or blank sheets of paper

SEE INSTRUCTION SHEET

Attach Supplemental Sheets or Forms Here

22 A Special qualifications and skills *(skills with machines, patents or inventions; your most important publications [do not submit copies unless requested]; your public speaking and publications experience; membership in professional or scientific societies, etc.)*

B Kind of license or certificate *(pilot, registered nurse, lawyer, radio operator, CPA, etc.)*	C Latest license or certificate: Year	State or other licensing authority	D Approximate number of words per minute: Typing	Shorthand

23 A Did you graduate from high school or will you graduate within the next nine months, or do you have a GED high school equivalency certificate?

Yes	Month and Year	No	Highest grade completed

B Name and location *(city and State)* of latest high school attended

C Name and location *(city, State, and ZIP Code, if known)* of college or university *(If you expect to graduate within nine months, give MONTH and YEAR you expect to receive your degree.)*	Dates Attended: From	To	Years Completed: Day	Night	No. of Credits Completed: Semester Hours	Quarter Hours	Type of Degree *(e.g., B.A.)*	Year of Degree

D Chief undergraduate college subjects	No. of Credits Completed: Semester Hours	Quarter Hours	E Chief graduate college subjects	No. of Credits Completed: Semester Hours	Quarter Hours

F Major field of study at highest level of college work

G Other schools or training *(for example, trade, vocational, Armed Forces or business)*. Give for each the name and location *(city, State and ZIP Code, if known)* of school, dates attended, subjects studied, number of classroom hours of instruction per week, certificate, and any other pertinent data.

24 Honors, awards, and fellowships received

25 Languages other than English. List the languages *(other than English)* in which you are proficient and indicate your level of proficiency by putting a check mark (✓) in the appropriate columns. **Candidates for positions requiring conversational ability in a language other than English may be given an interview conducted solely in that language.** Describe in item 34 how you gained your language skills and the amount of experience you have had *(e.g., completed 72 hours of classroom training; spoke language at home for 18 years; self-taught; etc.)*.

Name of Language(s)	PROFICIENCY: Can Prepare and Deliver Lectures: Fluently	With Difficulty	Can Converse: Fluently	Passably	Have Facility to Translate Articles, Technical Materials, etc.: Into English	From English	Can Read Articles, Technical Materials, etc. for Own Use: Easily	With Difficulty

26 References. List three persons who are NOT related to you and who have definite knowledge of your qualifications and fitness for the position for which you are applying. Do not repeat names of supervisors listed under item 21, Experience.

Full Name	Present Business or Home Address *(Number, Street, City, State and ZIP Code)*	Telephone Number *(Include Area Code)*	Business or Occupation

Answer items 27 through 33 by placing an "X" in the proper column	YES	NO
27 Are you a citizen of the United States? If "NO" give country of which you are a citizen		
NOTE: A conviction or a firing does not necessarily mean you cannot be appointed. The circumstances of the occurrence(s) and how long ago it (they) occurred are important. Give all the facts so that a decision can be made. 28 Within the last five years have you been fired from any job for any reason?		
29 Within the last five years have you quit a job after being notified that you would be fired? If your answer to 28 or 29 above is "YES" give details in Item 34. Show the name and address *(including ZIP Code)* of employer, approximate date, and reasons in each case. This information should agree with your answers in Item 21, Experience.		
30 A Have you **ever** been convicted, forfeited collateral, or are you now under charges for **any felony** or **any** firearms or explosives offense against the law? *(A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified under the laws of a State as a misdemeanor which is punishable by a term of imprisonment of two years or less.)*		
B During the past seven years have you been convicted, imprisoned, on probation or parole or forfeited collateral, or are you now under charges for any offense against the law not included in A above?		
NOTE: When answering A and B above, you may omit: (1) traffic fines for which you paid a fine of $50.00 or less, (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (3) any conviction the record of which has been expunged under Federal or State law, and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.		
31 While in the military service were you ever convicted by a general court-martial? If your answer to 30A, 30B, or 31 is "YES" give details in Item 34. Show for each offense: (1) date, (2) charge, (3) place, (4) court, and (5) action taken.		
32 Does the United States Government employ in a civilian capacity or as a member of the Armed Forces any relative of yours *(by blood or marriage)*? *(See Item 32 in the attached instruction sheet.)* If your answer to 32 is "YES" give in Item 34 for such relatives: (1) name, (2) present address *(including ZIP Code)*, (3) relationship, (4) department, agency, or branch of the armed forces.		
33 Do you receive, or do you have pending application for, retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia Government service? If your answer to 33 is "YES" give details in Item 34. If military retired pay, include the rank at which you retired.		

Your Statement cannot be processed until you have answered all questions, including Items 27 through 33 above. Be sure you have placed an "X" to the left of EVERY marker (◀) above, either in the "YES" or "NO" column.

34 Item No.	Space for detailed answers. Indicate item numbers to which the answers apply.

If more space is required, use full sheets of paper approximately the same size as this page. Write on each sheet your name, birth date, and announcement or position title. Attach all sheets to this Statement at the top of page 3.

ATTENTION—THIS STATEMENT MUST BE SIGNED

Read the following paragraphs carefully before signing this Statement

A false answer to any question in this Statement may be grounds for not employing you, or for dismissing you after you begin work, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001). All the information you give will be considered in reviewing your Statement.

AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited Investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose.

CERTIFICATION	SIGNATURE *(sign in ink)*	DATE
I certify that all of the statements made by me are true, complete and correct to the best of my knowledge and belief, and are made in good faith.		

Standard Form 173

JOB QUALIFICATIONS STATEMENT

IMPORTANT

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR STATEMENT

- You must provide all requested information. The information you provide will be used to determine your qualifications for employment.
- If you fail to answer all questions on your Statement fully and accurately, you may delay consideration of your Statement and lose employment opportunities. See the Privacy Act information on the back of this sheet.
- So that it is understood that you did not omit an item, please write the letters "N/A" (Not Applicable) beside those items that do not apply to you.

GENERAL INSTRUCTIONS FOR SUBMITTING THIS STATEMENT

- If you are applying for a specific Federal civil service examination:
  - —Read the examination announcement or the Qualifications Information Statement for the position to be certain that your experience and education are qualifying.
  - —If a written test is required, follow the filing instructions on the admission card.
  - —If no written test is required, mail this Statement to the Office of Personnel Management Area Office specified in the announcement or on the Qualifications Information Statement.
  - —Be sure to include all other forms required.
  - —If you have a change of name or address, notify the Office of Personnel Management Area Office with which you filed this Statement.
  - —You may want to make a copy of this Statement for your personal use.
- Volunteer Experience—In occupations for which experience is a factor, credit will be given for pertinent religious, civic, welfare, service and organizational activity performed either with or without pay. Show the actual time you spent in such activity (for example, average hours per week or month). Complete all the items just as you would for a paid position.

PLEASE DETACH THIS INSTRUCTION SHEET BEFORE SUBMITTING YOUR STATEMENT

ITEM 12. ACTIVE MILITARY SERVICE AND VETERAN PREFERENCE

- Five-point veteran preference is granted to veterans who receive an honorable or general discharge from the armed forces
  - (a) after active duty during the periods April 6, 1917, to July 2, 1921, and December 7, 1941, to July 1, 1955
  - (b) after more than 180 consecutive days of active duty, any part of which occurred after January 31, 1955, and before October 15, 1976
    NOTE—Service under an initial period of active duty for training under the "6-month" Reserve or National Guard programs is not creditable for veteran preference, and
  - (c) after service in a campaign for which a campaign badge has been authorized
- Non-disabled veterans who retired at or above the rank of major or its equivalent are not eligible for Veteran Preference after October 1, 1980. You will be required to furnish records to support your claim for five-point preference only at the time of your appointment.
- Ten-point veteran preference is granted to
  - (a) disabled veterans, and
  - (b) veterans awarded the Purple Heart.

  Ten-point veteran preference is granted in certain cases to
  - (a) unmarried widows and widowers of veterans,
  - (b) spouses of disabled veterans, and
  - (c) mothers of deceased or disabled veterans.

  If you claim ten-point veteran preference, submit Standard Form 15, Claim for 10-Point Veteran Preference, and the required proof with this application. Obtain SF 15 and information on provisions of the Veteran Preference laws at any Federal Job Information Center.
- A clemency discharge does not meet the Veteran Preference Act requirement for discharge under honorable conditions. Accordingly, no preference may be granted to applicants with such discharge.

PRIVACY ACT INFORMATION

The Office of Personnel Management is authorized to rate applicants for Federal jobs under sections 1302, 3301, and 3304 of Title 5 of the U.S. Code. We need the information you put on this form to see how well your education and work skills qualify you for a Federal job. We also need information on matters such as citizenship and military service to see whether you are affected by laws we must follow in deciding who may be employed by the Federal Government. We cannot give you a rating, which is the first step toward getting a job, if you do not answer these questions.

We must have your Social Security Number (SSN) to keep your records straight because other people may have the same name and birthdate. The SSN has been used to keep records since 1943, when Executive Order 9397 asked agencies to do so. The Office of Personnel Management may also use your SSN to make requests for information about you from employers, schools, banks, and others who know you, but only as allowed by law. The information we collect by using your SSN will be used for employment purposes and also for studies and statistics that will not identify you.

Information we have about you may also be given to Federal, State, and local agencies for checking on law violations or for other lawful purposes. We may also notify your school placement office if you are selected for a Federal job.

Standard Form 173 (Rev. 1/78)
Office of Personnel Management
FPM Chapter 295

JOB QUALIFICATIONS STATEMENT

(Complete All Questions)

PLEASE USE A TYPEWRITER IF AVAILABLE, OR PRINT LEGIBLY IN INK

Form Approved:
OMB No. 3206-0003

1 Kind of job you are applying for

2 Announcement number of the job, if appropriate

3 Name *(Last, first, middle)*

4 Sex *(for statistics only)* ☐ Male ☐ Female

5 Other last names ever used

Street address or RFD no. *(Include apt. no., if any)*

6 Birth date *(Month, day, year)*

7 Birthplace *(City and State or foreign country)*

City | State | ZIP Code

8 Social Security Number

9 Telephone number where you can be reached — Area Code | Telephone Number

10 EXPERIENCE—If you are now employed, start with your present job and work back. If you are not now employed, start with your most recent job and work back.

If you are now employed, is it OK to check with your present employer? *(A "NO" will not affect your consideration for employment opportunities)*..... ☐ YES ☐ NO

A Name and address *(Including ZIP Code)* of employer

Dates of work *(Month and year)* From | To

Name of your job

Average number of hours you worked per week

Starting wages | Present or final wages

Per ☐ Hour ☐ Week ☐ Year

Name of your supervisor

Why do you want to leave?

What do you do?

B Name and address *(Including ZIP Code)* of employer

Dates of work *(Month and year)* From | To

Name of your job

Average number of hours you worked per week

Starting wages | Final wages

Per ☐ Hour ☐ Week ☐ Year

Name of your supervisor

Why did you leave?

What did you do?

C Name and address *(Including ZIP Code)* of employer

Dates of work *(Month and year)* From | To

Name of your job

Average number of hours you worked per week

Starting wages | Final wages

Per ☐ Hour ☐ Week ☐ Year

Name of your supervisor

Why did you leave?

What did you do?

If you need more space to show your work experience, or for any other item, use Item 20 on the back of this form or use a plain sheet of paper and attach it to this form. Put your name, birth date, and kind of job you are applying for at the top of each sheet.

11 A EDUCATION—Did you graduate from high school or will you graduate within the next nine months, or do you have a GED high school equivalency certificate?

YES | Month and Year | NO | Highest Grade Completed

B Trade or technical schools attended *(Dates attended, name of school, and subjects studied)*

12 ACTIVE MILITARY SERVICE AND VETERAN PREFERENCE

A Dates of active service *(Month, day, year)* From | To

B Branch of service *(Army, Navy, Air Force, etc.)*

C Serial or service number

D Kind of discharge ☐ Honorable or General ☐ Other

E Do you claim Veteran Preference? ☐ YES ☐ NO If "YES," check type ☐ Five-point preference ☐ Ten-point preference *(Compensable disability 30% or more)* ☐ Other ten-point preference *(Complete and attach Standard Form 15, Claim for Ten-point Veteran Preference)*

13 A Special qualifications and skills *(Skills with machines and tools, patents, inventions, etc.)*

B Kind of license or certificate *(Licensed Practical Nurse, radio operator, driver's license, etc.)*

C Latest license or certificate Year | State or other licensing authority

D Approximate number of words per minute Typing | Shorthand

THE FEDERAL GOVERNMENT IS AN EQUAL OPPORTUNITY EMPLOYER

(173-103)

7540-00-142-8757 PREVIOUS EDITION USABLE

14 REFERENCES—Give the names of three persons living in the United States who know you well. Do not list the names of relatives or supervisors you gave under Item 10.

NAME	OFFICE OR HOME ADDRESS	ZIP CODE

ANSWER ITEMS 15 THROUGH 19 BY PLACING AN "X" IN THE PROPER COLUMN	YES	NO
15 Are you a citizen of the United States? If "NO" give the country of which you are a citizen		
NOTE: A conviction or a firing does not necessarily mean you cannot be appointed. The circumstances of the occurrence(s) and how long ago it (they) took place is important. Give all the facts so that a decision can be made.		
16 Within the last five years have you been fired from any job for any reason?		
17 Within the last five years have you quit a job after being notified that you would be fired? If your answer to 16 or 17 above is "YES" give details in Item 20. Show the name and address *(including ZIP Code)* of employer, approximate date, and reasons in each case. This information should agree with your answers in Item 10, Experience.		
18 A. Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? *(A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified under the laws of a State as a misdemeanor which is punishable by a term of imprisonment of two years or less.)*		
B. During the past seven years have you been convicted, imprisoned, on probation or parole or forfeited collateral, or are you now under charges for any offense against the law not included in A, above?		
NOTE: When answering A and B above, you may omit: (1) traffic fines for which you paid a fine of $50.00 or less, (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (3) any conviction the record of which has been expunged under Federal or State law, and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.		
19 While in the military service were you ever convicted by a general court-martial? If your answer to 18A, 18B, or 19 is "YES" give details in Item 20. Show for each offense: (1) date, (2) charge, (3) place, (4) court, and (5) action taken.		

20 Item No.	Space for detailed answers. Indicate item numbers to which answers apply

ATTENTION—THIS STATEMENT MUST BE SIGNED

Read the Following Paragraphs Carefully Before Signing This Statement

A false answer to any question in this Statement may be grounds for not employing you, or for dismissing you after you begin work, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001). All the information you give will be considered in reviewing your Statement.

AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose.

CERTIFICATION	Signature of applicant *(Sign in ink)*	Date signed
I certify that all of the statements by me are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.		

DO NOT WRITE BELOW THIS LINE

NOTATIONS	OPTION	GRADE	RATING EARNED	PREFERENCE	AUGM. RATING
APPROVED				☐ BEING INV INITIALS & DATE	
APP. REVIEW				☐ LESS THAN 30% ☐ 10 COMP. DIS OVER 30% ☐ 10 COMP. DIS ☐ 10 OTHER ☐ 5 PT	

The information in answer to Item 12 has been verified with the discharge certificate which shows that the separation from active duty was under honorable conditions.

SIGNATURE _____ AGENCY _____

DATE _____

SF 173 (Rev. 1-79) Back

Standard Form 173

JOB QUALIFICATIONS STATEMENT

IMPORTANT

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR STATEMENT

- You must provide all requested information. The information you provide will be used to determine your qualifications for employment.
- If you fail to answer all questions on your Statement fully and accurately, you may delay consideration of your Statement and lose employment opportunities. See the Privacy Act information on the back of this sheet.
- So that it is understood that you did not omit an item, please write the letters "N/A" (Not Applicable) beside those items that do not apply to you.

GENERAL INSTRUCTIONS FOR SUBMITTING THIS STATEMENT

- If you are applying for a specific Federal civil service examination:
  - —Read the examination announcement or the Qualifications Information Statement for the position to be certain that your experience and education are qualifying.
  - —If a written test is required, follow the filing instructions on the admission card.
  - —If no written test is required, mail this Statement to the Office of Personnel Management Area Office specified in the announcement or on the Qualifications Information Statement.
  - —Be sure to include all other forms required.
  - —If you have a change of name or address, notify the Office of Personnel Management Area Office with which you filed this Statement.
  - —You may want to make a copy of this Statement for your personal use.
- Volunteer Experience—In occupations for which experience is a factor, credit will be given for pertinent religious, civic, welfare, service and organizational activity performed either with or without pay. Show the actual time you spent in such activity (for example, average hours per week or month). Complete all the items just as you would for a paid position.

PLEASE DETACH THIS INSTRUCTION SHEET BEFORE SUBMITTING YOUR STATEMENT

ITEM 12. ACTIVE MILITARY SERVICE AND VETERAN PREFERENCE

- Five-point veteran preference is granted to veterans who receive an honorable or general discharge from the armed forces
  - (a) after active duty during the periods April 6, 1917, to July 2, 1921, and December 7, 1941, to July 1, 1955
  - (b) after more than 180 consecutive days of active duty, any part of which occurred after January 31, 1955, and before October 15, 1976
    NOTE—Service under an initial period of active duty for training under the "6-month" Reserve or National Guard programs is not creditable for veteran preference, and
  - (c) after service in a campaign for which a campaign badge has been authorized
- Non-disabled veterans who retired at or above the rank of major or its equivalent are not eligible for Veteran Preference after October 1, 1980. You will be required to furnish records to support your claim for five-point preference only at the time of your appointment.
- Ten-point veteran preference is granted to
  - (a) disabled veterans, and
  - (b) veterans awarded the Purple Heart.

  Ten-point veteran preference is granted in certain cases to
  - (a) unmarried widows and widowers of veterans,
  - (b) spouses of disabled veterans, and
  - (c) mothers of deceased or disabled veterans.

  If you claim ten-point veteran preference, submit Standard Form 15, Claim for 10-Point Veteran Preference, and the required proof with this application. Obtain SF 15 and information on provisions of the Veteran Preference laws at any Federal Job Information Center.
- A clemency discharge does not meet the Veteran Preference Act requirement for discharge under honorable conditions. Accordingly, no preference may be granted to applicants with such discharge.

PRIVACY ACT INFORMATION

The Office of Personnel Management is authorized to rate applicants for Federal jobs under sections 1302, 3301, and 3304 of Title 5 of the U.S. Code. We need the information you put on this form to see how well your education and work skills qualify you for a Federal job. We also need information on matters such as citizenship and military service to see whether you are affected by laws we must follow in deciding who may be employed by the Federal Government. We cannot give you a rating, which is the first step toward getting a job, if you do not answer these questions.

We must have your Social Security Number (SSN) to keep your records straight because other people may have the same name and birthdate. The SSN has been used to keep records since 1943, when Executive Order 9397 asked agencies to do so. The Office of Personnel Management may also use your SSN to make requests for information about you from employers, schools, banks, and others who know you, but only as allowed by law. The information we collect by using your SSN will be used for employment purposes and also for studies and statistics that will not identify you.

Information we have about you may also be given to Federal, State, and local agencies for checking on law violations or for other lawful purposes. We may also notify your school placement office if you are selected for a Federal job.

☆ U.S. GOVERNMENT PRINTING OFFICE : 1982 O - 381-526 (8177)

Standard Form 173 (Rev. 1/79)
Office of Personnel Management
FPM Chapter 295

JOB QUALIFICATIONS STATEMENT

(Complete All Questions)

PLEASE USE A TYPEWRITER IF AVAILABLE, OR PRINT LEGIBLY IN INK

Form Approved:
OMB No. 3206-0003

1 Kind of job you are applying for

2. Announcement number of the job, if appropriate

3 Name *(Last, first, middle)*

4. Sex *(for statistics only)* ☐ Male ☐ Female

5. Other last names ever used

Street address or RFD no. *(Include apt. no., if any)*

6. Birth date *(Month, day, year)*

7. Birthplace *(City and State or foreign country)*

City | State | ZIP Code

8. Social Security Number

9. Telephone number where you can be reached — Area Code | Telephone Number

10 EXPERIENCE—If you are now employed, start with your present job and work back. If you are not now employed, start with your most recent job and work back.

If you are now employed, is it OK to check with your present employer? *(A "NO" will not affect your consideration for employment opportunities)*..... ☐ YES ☐ NO

A Name and address *(Including ZIP Code)* of employer

Dates of work *(Month and year)* From | To

Name of your job

Average number of hours you worked per week

Starting wages | Present or final wages

Per ☐ Hour ☐ Week ☐ Year

Name of your supervisor

Why do you want to leave?

What do you do?

B Name and address *(Including ZIP Code)* of employer

Dates of work *(Month and year)* From | To

Name of your job

Average number of hours you worked per week

Starting wages | Final wages

Per ☐ Hour ☐ Week ☐ Year

Name of your supervisor

Why did you leave?

What did you do?

C Name and address *(Including ZIP Code)* of employer

Dates of work *(Month and year)* From | To

Name of your job

Average number of hours you worked per week

Starting wages | Final wages

Per ☐ Hour ☐ Week ☐ Year

Name of your supervisor

Why did you leave?

What did you do?

If you need more space to show your work experience, or for any other item, use Item 20 on the back of this form or use a plain sheet of paper and attach it to this form. Put your name, birth date, and kind of job you are applying for at the top of each sheet.

11 A EDUCATION—Did you graduate from high school or will you graduate within the next nine months, or do you have a GED high school equivalency certificate?

YES ☐ | Month and Year | NO ☐ | Highest Grade Completed

B Trade or technical schools attended *(Dates attended, name of school, and subjects studied)*

12 ACTIVE MILITARY SERVICE AND VETERAN PREFERENCE

A Dates of active service *(Month, day, year)* From | To

B Branch of service *(Army, Navy, Air Force, etc.)*

C Serial or service number

D Kind of discharge ☐ Honorable or General ☐ Other

E Do you claim Veteran Preference? ☐ YES ☐ NO If "YES," check type ☐ Five-point preference ☐ Ten-point preference *(Compensable disability 30% or more)* ☐ Other ten-point preference *(Complete and attach Standard Form 15, Claim for Ten-point Veteran Preference)*

13 A Special qualifications and skills *(Skills with machines and tools, patents, inventions, etc.)*

B Kind of license or certificate *(Licensed Practical Nurse, radio operator, driver's license, etc.)*

C Latest license or certificate — Year | State or other licensing authority

D Approximate number of words per minute — Typing | Shorthand

14 REFERENCES—Give the names of three persons living in the United States who know you well. Do not list the names of relatives or supervisors you gave under Item 10.

NAME	OFFICE OR HOME ADDRESS	ZIP CODE

ANSWER ITEMS 15 THROUGH 19 BY PLACING AN "X" IN THE PROPER COLUMN	YES	NO
15 Are you a citizen of the United States? If NO, give the country of which you are a citizen		
NOTE: A conviction or a firing does not necessarily mean you cannot be appointed. The circumstances of the occurrence(s) and how long ago it (they) took place is important. Give all the facts so that a decision can be made.		
16 Within the last five years have you been fired from any job for any reason?		
17 Within the last five years have you quit a job after being notified that you would be fired? If your answer to 16 or 17 above is "YES", give details in Item 20. Show the name and address (including ZIP Code) of employer, approximate date, and reasons in each case. This information should agree with your answers in Item 10, Experience.		
18 A. Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? *(A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified under the laws of a State as a misdemeanor which is punishable by a term of imprisonment of two years or less).*		
B. During the past seven years have you been convicted, imprisoned, on probation or parole or forfeited collateral, or are you now under charges for any offense against the law not included in A above?		
NOTE: When answering A and B above, you may omit: (1) traffic fines for which you paid a fine of $50.00 or less, (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (3) any conviction the record of which has been expunged under Federal or State law, and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.		
19 While in the military service were you ever convicted by a general court-martial? If your answer to 18A, 18B, or 19 is "YES", give details in Item 20. Show for each offense: (1) date, (2) charge, (3) place, (4) court, and (5) action taken.		

20 Item No.	Space for detailed answers. Indicate item numbers to which answers apply

ATTENTION—THIS STATEMENT MUST BE SIGNED

Read the Following Paragraphs Carefully Before Signing This Statement

A false answer to any question in this Statement may be grounds for not employing you, or for dismissing you after you begin work, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001). All the information you give will be considered in reviewing your Statement.

AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose.

CERTIFICATION	Signature of applicant *(Sign in ink)*	Date signed
I certify that all of the statements by me are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.		

DO NOT WRITE BELOW THIS LINE

NOTATIONS	OPTION	GRADE	RATING EARNED	PREFERENCE	ADJUDICATING RATING
APPROVED				☐ 5 PT ☐ 10 OTHER ☐ 10 COMP. DIS. OVER 30% ☐ 10 COMP. DIS. LESS THAN 30% ☐ VETERAN INITIALS & DATE	
APP. REVIEW					

The information in answer to Item 12 has been verified with the discharge certificate which shows that the separation from active duty was under honorable conditions.

DATE _____ AGENCY _____

SIGNATURE _____

SF 173 (Rev. 1-79) Back

STUDY AND ACADEMIC RESPONSIBILITIES

You, the student, are responsible for your academic progress and success. However, the IHS and the academic institution you are attending are available to provide the necessary support and assistance you require to ensure success. This section of the Scholarship Program Handbook describes some tips on studying and some requirements that are your responsibility.

Study Plan

You are responsible for developing a study plan and providing a copy of that plan to your Area Scholarship Coordinator each month. The study plan and scheduling system has three phases (see sample):

(1) Meet with the student advisor or a faculty person to get assistance in determining study problems and to develop a time management system.

(2) The student advisor or faculty person will help you develop a schedule that is time-managed. You are responsible for scheduling and meeting weekly with your advisor to make out new study plans and to assess the success of the previous week's plan (as well as to note changes in the previous week's plan). Your advisor will also provide tips for developing successful study habits as well as feedback to based upon the plan.

(3) You develop your study plan and independently monitor your progress.

"Study and Academic Responsibilities" Section Printed with the Permission of:

Henry T. Frierson, Jr., Ph.D.
University of North Carolina at Chapel Hill

STUDY PLAN - LECTURE*

TIME	NOTETAKING	TEXTBOOK	HANDOUTS
BEFORE LECTURE		Read the assigned pages or at least read special type (italics, etc.).	Read the assigned pages or at least scan terminology. Organize objectives.
DURING LECTURE	Identify lecture. Write everything, one side of page only.		
IMMEDIATELY AFTER LECTURE	5-minute recap: Identify important topic(s) and what you need to know about each topic.		
SAME DAY	Fill in notes. On opposite page: organize & summarize information. Integrate information from handouts. Integrate information from textbook Review notes	Read, mark-up	Complete, as appropriate.
SAME WEEK	Integrate information from textbook Review notes	Complete reading and marking-up	
END OF TOPIC	Prepare review materials Check: complete consistent clear Review notes	Review reading assignments	Review handouts

*Adapted from a model developed by M. Willey and B. Jarocky

EXAMPLE OF A MEDICAL STUDENT'S SCHEDULE

FIXED

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
8-9 Breakfast	"	"	"	"	"	"
9-11 Histology	Path 9-11	9-11 Histology	Path 9-11	9-11 Study Group	9-12 Neuro	9-10 Path Reading
11-12 Histology Review	Path Review 11-12	11-12 Histology Review	Path Review 11-12	11-12 Reading Lab		10-1 Church
12-1 Lunch	Lunch 12-1	Lunch 12-1	Lunch 12-1	Lunch 12-1	Lunch 12-1	Dinner 1-2:30
1-4 Neurophysiology	Biochem 1-4	1-4 Neuro	Biochem 1-4	Histology Reading 1-6	Biochem Reading 1-5	2:30-6 Biochem
4-5 Neurophys	4-5 Biochem Review	4-5 Neuro Review	4-5 Biochem Review	My time 6-until	5-8 Path Reading	6-7 Supper
5-6 Dinner	5-6 Dinner	5-6 Dinner	5-6 Dinner		My time 8-until	7-8 Preview for week
6-8 Pathology 8-9 Exercise 9-12 Prepare for Tues. lect.	6-8 Histology 8-9 Exercise 9-12 Prepare for Wed. lect.	6-8 Neuro 8-9 Exercise 9-12 Prepare for Thurs. lec.	6-8 Biochem 8-9 Exercise 9-12 Prepare for Fri. lect.			8-12 Preview for Monday's lectures

EXAMPLE OF A MEDICAL STUDENT'S SCHEDULE

FLEXIBLE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
9-1 Histology	9-1 Path.	9-1 Histology	9-1 Path.	9-11 Biochem	9 am - 9 pm Reading	1-11 pm Review of week and preview of next week
1-5 Neuro.	1-5 Biochem	1-5 Neuro,	1-5 Biochem	11-12 Study Group Biochem	8-until My time	Prepare for Monday's lecture
5-6:30 Dinner & Break	5-6:30 Dinner & Break	5-6:30 Dinner & Break	5-6:30 Dinner & Break	12-6 Text Reading		
6:30-9 Reading and Review	6:30-9 Reading and Review	6:30-9 Reading and Review	6:30-9 Reading and Review	6-until My time		
9-12 Prepare for Tues. Lectures	9-12 Prepare for Weds. Lectures	9-12 Prepare for Thurs. Lectures	9-12 Prepare for Fri. Lectures			

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

* U.S. GOVERNMENT PRINTING OFFICE: 1984-426-893:30400